185744

Class _____ *No.* _____

In Exchange.

Bdg.2.70

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Digitized by the Internet Archive
in 2016

https://archive.org/details/wisconsinmedical5219stat

The

WISCONSIN MEDICAL JOURNAL

OWNED and PUBLISHED by the STATE MEDICAL
SOCIETY of WISCONSIN

A Monthly Journal of Medicine and Surgery

VOLUME LII
JANUARY 1953–DECEMBER 1953

THE WISCONSIN MEDICAL JOURNAL

EDITORIAL STAFF

R. S. BALDWIN, Marshfield, *Medical Editor*
J. M. SULLIVAN, Milwaukee, *Editorial Director*
MR. C. H. CROWNHART, Madison, *Managing Editor*
MR. ROY T. RAGATZ, Madison, *Advertising Manager*
MRS. DOROTHY P. REINHARDT, Madison, *Assistant Editor*

EDITORIAL BOARD

H. KENT TENNEY, Madison
D. W. OVITT, Milwaukee
ELWOOD MASON, Milwaukee
CHALMER DAVEE, River Falls
G. E. FORKIN, Menasha

THE COUNCIL ON SCIENTIFIC WORK

T. O. NUZUM, Janesville, *Chairman*
J. W. GALE, Madison
S. A. MORTON, Milwaukee
P. A. MIDELFART, Eau Claire
M. G. RICE, Stevens Point
R. S. BALDWIN, Marshfield, *(ex officio)*
J. S. HIRSCHBOECK, Milwaukee, *(ex officio)*
W. S. MIDDLETON, Madison, *(ex officio)*

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, *President*
H. KENT TENNEY, Madison, *President-Elect*
G. E. FORKIN, Menasha, *Speaker*
J. W. FONS, Milwaukee, *Vice-Speaker*
F. L. WESTON, Madison, *Treasurer*
MR. C. H. CROWNHART, Madison, *Secretary*

COUNCILORS

R. G. ARVESON, Frederic, *Chairman*
S. E. GAVIN, Fond du Lac, *Chairman Emeritus*

Term Expires 1954

First District:
W. H. Costello---Beaver Dam

Second District:
T. C. Hemmingsen-----Racine

Term Expires 1955

Third District:
N. A. Hill----------Madison

Term Expires 1954

H. E. Kasten----------Beloit

Term Expires 1955

Fourth District:
E. M. Dessloch–Prairie du Chien

Term Expires 1955

Fifth District:
A. H. Heidner-----West Bend

Sixth District:
A. J. McCarey-----Green Bay

Term Expires 1953

Seventh District:
J. C. Fox----------La Crosse

Eighth District:
J. M. Bell----------Marinette

Ninth District:
E. E. Kidder----Stevens Point

Tenth District:
R. G. Arveson-------Frederic
(Chairman)

Term Expires 1954

Eleventh District:
V. E. Ekblad--------Superior

Twelfth District:
R. E. Galasinski---Milwaukee
E. L. Bernhart-----Milwaukee
N. J. Wegmann----Milwaukee

Term Expires 1955

W. T. Casper------Milwaukee

Term Expires 1953

Thirteenth District:
C. E. Zellmer---------Antigo

Term Expires 1953

A. H. Heidner-----West Bend
(Past-President)

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

ALTERNATES

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

. . . . THE PRESIDENT'S PAGE . . . .

IT HAS proven to be timely and appropriate that the new Commission on State Departments was authorized by your House of Delegates at its last meeting.

This is a nine man commission, each member a chairman of his own special committee, that is to be advisory to all state departments operating health care and public health programs.

The whole matter of public health, the prevention and control of contagious diseases, public hygiene and sanitation, and the assurance of a safe water and milk supply, was the original interest of government in the field of medicine, and rightly so.

Since then health legislation has increased locally and nationally so that surprising sums are being spent by the government in health activities. Tuberculosis and chest diseases, maternal and child welfare, handicapped children, school health, hearing and visual defects, mental hygiene and institutional care, and old age and public assistance are some of them.

We, as physicians who consider ourselves responsible for the health of the people under our care, should, and do, concern ourselves with the health, welfare, and happiness of the people as a whole. Health needs will vary somewhat in rural and metropolitan areas, and we, as individual physicians, should acquaint ourselves with the particular needs in our own communities so that we may be prepared through this Commission on State Departments to present the physician's viewpoint in these health problems. Only by frank discussions with government agencies, representatives of hospitals and nurses' organizations, and professional health and welfare workers can we arrive at a policy that will best serve the health needs of the people of Wisconsin.

Nationally, the recent report of the President's Commission on Health Needs of the Nation recommended what it called a "middlecourse" for the future. It was very reassuring that instead of compulsory national health insurance, which organized medicine has violently opposed, it favored the system of voluntary prepayment insurance which medicine has fostered and promoted but which does not yet seem to cover enough of the people or provide a method of covering sufficiently the very expensive catastrophic illnesses.

Debatable points in the report are the proposals to use Social Security funds to pay insurance premiums for those drawing old age and survivors benefits and joint federal and state payment of premiums of those either on relief or otherwise unable to pay for medical care. The intent of these proposals is perhaps laudable, but the use of Social Security funds from payroll deductions to pay insurance premiums is government insurance for at least a portion of the people, and a federal-state program for people on relief would be administered under a federal pattern with rules and standards that the state would have to meet and would be one more instance of the nationalization of a function now carried on by local government.

The American Medical Association proposes to have a committee study the entire report. It would seem timely and appropriate that our new Commission on State Departments familiarize itself with the report, and, in addition, become thoroughly acquainted with the actual health needs in Wisconsin.

J. C. Griffith M.D.

182311
JUN 16 1954

Who's Who in Health in Wisconsin

A Directory of Voluntary and Governmental Agencies in the Field of Public Health

AMERICAN CANCER SOCIETY, WISCONSIN DIVISION

F. J. WILCOX

President: Francis J. Wilcox

Executive Director: Robert O. McLean

Address: 652 E. Gorham St., Madison 3, Wisconsin

Phone: 5-8879

This voluntary organization directs its activities into two major channels —to physicians and to the general public. For physicians, the Society offers postgraduate courses and films, journals, monographs, and slides on a loan basis. For the public, the Society engages in research into the causes and relief of cancer, education for the prevention of cancer, and service to individuals suffering with cancer. Dressings are available in every county for home or hospitalized patients. Physicians are urged to contact county cancer units for dressings or loan closet materials. Traveling postgraduate cancer clinics are held each year for physicians. In addition, there are annual cancer institutes for nurses, dentists and teachers. Speakers and exhibits are provided for professional meetings of all types.

AMERICAN RED CROSS

Director, Badger Regional Blood Center: Merle O. Hamel, M. D.

Administrative Director: George Hibner

Address: 302 East Washington Avenue, Madison, Wisconsin

Phone: 5-0021

M. O. HAMEL, M. D.

Blood and some of its by-products are distributed to civilian hospitals in counties comprising the territories of 32 Red Cross Chapters participating in the Badger Regional Blood program; immune serum globulin is distributed by the State Board of Health to health officers throughout the entire state upon request to the State Board of Health. This organization also distributes serum albumin directly to doctors in limited quantities and upon request. Northwest Wisconsin is served by the St. Paul Regional Blood Program. County chapters provide instruction in home care of the sick, first aid and water safety, recruitment of nurses to be assigned to polio treatment centers and instruction in the health aspects of food and nutrition.

DEPARTMENT OF PUBLIC INSTRUCTION

G. E. WATSON

State Superintendent: George E. Watson

Address: 147 North, State Capitol, Madison, Wisconsin

Phone: 6-4411, Ext. 589

Through supervision of elementary and secondary schools of Wisconsin this department is concerned with the health of school people. A special supervisor in health and physical education conducts health activities among school students and personnel. A building services division is concerned about health and sanitation aspects of school buildings under the department's supervisory jurisdiction. In the Bureau of Handicapped Children several programs are carried out which involve medical services. Each year about 200,000 children obtain audiometric tests. Hearing difficulties discovered in these tests are referred to otologic clinics in which county medical societies participate. Aid is provided crippled children and those with rheumatic fever. Programs are provided for the deaf and the hard of hearing. Physicians are requested to contact the Bureau whenever they have questions or referrals to make concerning children who might qualify for assistance.

DEPARTMENT OF PUBLIC WELFARE

Director: John W. Tramburg

Address: State Capitol, Madison, Wisconsin

Phone: 6-4411, Ext. 681

J. W. TRAMBURG

This department is responsible for more than $30,000,000 in state property and annual expenditure of $60,000,000 of federal, state and local funds. It administers laws concerning the charitable, curative, correctional and penal institutions and services, and laws concerning old age assistance, aid to dependent children, aid to the blind, and relief. It supervises medical and therapeutic treatment of patients in the hospitals for mental diseases, colonies for the mentally deficient, and the county hospitals for the mentally ill. It operates the bureau of alcohol studies, program for adult blind, and student loan fund for needy college students. It provides medical and health services to many aged, juvenile, needy, and physically handicapped persons through private practitioners.

DEPARTMENT OF VETERANS AFFAIRS

G. A. HUSEBY

Director: Gordon A. Huseby

Address: Rm. 12A, South, State Capitol, Madison, Wisconsin

Phone: 6–4411, Ext. 311

This department renders health, educational, and economic assistance to veterans of the armed forces of World War II and the Korean conflict and their dependents. Medical or hospital care is contingent upon the temporary emergency aid and there being evidence of want or distress. Misconduct or lack of compliance with the law precludes favorable consideration. Prior authorization is a prerequisite for other than emergencies in which event notice must be filed with the department within five days. Applications should be initiated through the county veterans service officer of the county in which the veteran resides.

INDUSTRIAL COMMISSION

Chairman: Voyta Wrabetz

Secretary: Miss Helen E. Gill

Address: 1 West Wilson St., Madison, Wisconsin

Phone: 6–4411, Ext. 786

VOYTA WRABETZ

The commission administers workmen's compensation laws and regulations pertaining to safety and sanitation. The compensation act provides for payment of compensation and for all necessary medical treatment to injured employees of employers subject to the act. The State Medical Society's "Open Panel" program is part of the administration of the workmen's compensation act.

MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY

O. M. DRESEN, D.D.S.

Dean: O. M. Dresen, D.D.S.

Secretary: R. G. Haukohl

Address: 604 N. Sixteenth Street, Milwaukee 3, Wisconsin

Phone: Division 4–1000

This is the only center of dental education in Wisconsin. A maximum of 115 freshmen dental students and 42 dental hygiene students are accepted in the fall of each year. Dental students are required to have a minimum of two years of pre-dental liberal arts college before admission to the dental school, and receive four years of training in the dental school.

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

J. H. HIRSCHBOECK, M. D.

Dean: John S. Hirschboeck, M. D.

Address: 561 No. 15th St., Milwaukee, Wisconsin

Phone: Division 4–1000, Ext. 341

Marquette University School of Medicine conducts an educational program for the undergraduate training of men and women for the practice of medicine. It also conducts postgraduate courses for physicians, supervises the training of physicians for the medical specialities, and conducts an educational training program in physical therapy, leading to either a B.S.C. in physiotherapy or a certificate in therapy. The school operates the Variety Club Heart Center, a diagnostic unit for special study in heart diseases; the Milwaukee Cancer Diagnostic Clinic, and the Marquette Eye Clinic.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

Southern Wisconsin Representative: Francis Strapp

Address: 119 E. Washington Avenue, Madison, Wisconsin

Phone: 5–5824

Northern Wisconsin Representative: Norman E. Weaver

Address: 508 First Street, Wausau, Wisconsin

Phone: 8–9166

The Foundation offers (1) a patient care program in which polio patients receive direct financial aid as needed for the payment of hospital and medical bills, procurement of appliances, transportation to medical centers, etc.; (2) epidemic services which provide emergency equipment such as respirators, hot pack machines, rocking beds, and aid in obtaining and financing emergency personnel; (3) professional education including a program of scholarships, fellowships, and grants to increase the number of technicians and medical specialists needed for polio care and treatment. Patient care aid is obtained directly from county chapters of the Foundation.

FRANCIS STRAPP

N. E. WEAVER

OFFICE OF CIVIL DEFENSE

Director: Major General Ralph J. Olson

Co-director for Health Services: Carl N. Neupert, M. D.

Address: 25 East, State Capitol, Madison 2, Wisconsin

Phone: 6-4411, Ext. 424

MAJ. GEN. R. J. OLSON

The office of Civil Defense is building 102 medical teams in the state mobile support program; stock-piling medical supplies for these teams; arranging for blood to be procured for their use; arranging with hospitals to expand their facilities to accommodate casualties, van ambulances to transport casualties from first-aid stations to hospitals; and outpatient care of casualties. State and county medical societies have supplied the pattern which is being followed in building these medical teams. The state office is training the radiologic monitors for the teams and is assisting in training such specialists in political subdivisions. A technical manual for medical teams to use in their operations is nearing completion.

STATE BOARD OF DENTAL EXAMINERS

F. J. MARTIN, D. D. S.

President: F. J. Martin, D. D. S.

Address: Tomah

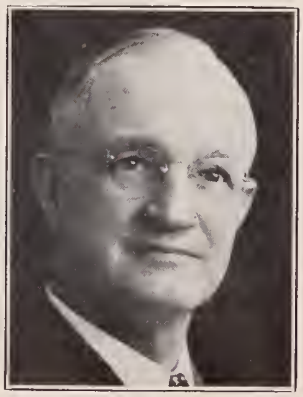
The board is composed of five members appointed by the governor for five-year terms. It is the duty of the board to conduct examinations for license to practice dentistry and dental hygiene, to admit dentists from other states after examining their qualifications, and to revoke licenses for cause. The board must decide that dentists desiring to practice in Wisconsin are ethical and capable of providing high quality dental care.

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

Secretary: W. H. Barber

Address: 621 Ransom Street, Ripon, Wisconsin

Phone: Black 564



W. H. BARBER

The board grants certificates of proficiency in the basic sciences (anatomy, physiology, pathology, and diagnosis) on the basis of examination or reciprocity. Examinations are held four times each year at such times and places as the board may choose. Candidates are required to present evidence of graduation from an accredited high school or its equivalent and two affidavits as to good moral character. The State Board of Medical Examiners, the State Board of Examiners in Chiropractic, and the State Board of Dental Examiners are required by law not to admit to their examinations or license or register any applicant unless such applicant first presents a certificate of registration in the basic sciences.

STATE BOARD OF HEALTH

S. E. GAVIN, M. D.

President: Stephen E. Gavin, M. D.

State Health Officer: Carl N. Neupert, M. D.

Address: Rm. 400, State Office Bldg., Madison 2, Wisconsin

Phone: 6-4411, Ext. 511

The State Board of Health has general supervision of the health and life of citizens throughout the state. This department directs activities involving vital statistics, laboratories, dental and health education, hospital construction, cosmetology, barbering, funeral directing and embalming, communicable diseases, tuberculosis, venereal disease, cancer and heart disease control, sanitary engineering, plumbing, well drilling, rendering and slaughtering, water pollution control, maternal and child health, school health nutrition, mental health, local health administration, public health nursing, industrial hygiene, and hotels and restaurants. The Board is vested with prescribed powers of regulation and enforcement in matters pertaining to public health. The Board determines policies for the administration of the department and adopts rules and regulations pertaining to its statutory functions. Nine district health offices assist local boards of health and health officers in all towns, villages, and cities of the state in supplementing the work of the department. Also under its supervision is the State Laboratory of Hygiene in Madison. The Board publishes a Biennial Report, Health (a bimonthly bulletin) special publications and pamphlets on a wide variety of health topics, and a catalogue of health films.

STATE BOARD OF MEDICAL EXAMINERS

President: J. W. Prentice, M. D.

Secretary: A. G. Koehler, M. D.

Address: 46 Washington Boulevard, Oshkosh, Wisconsin

Phone: Blackhawk 137

J. W. PRENTICE, M. D.

The Board was created in 1897. It licenses applicants to practice medicine and surgery, osteopathy, chiropody and massage. The Board also has the duty of enforcing the regulations of the Medical Practice Act, in connection with which it employs a full-time investigator. Members of the Board are appointed for terms of four years.

STATE BOARD OF PHARMACY

President: Milton E. Nichols

Secretary: Sylvester H. Dretzka

Address: 794 North Jefferson Street, Milwaukee, Wis.

Phone: Broadway 6-0394

M. E. NICHOLS

The board examines applicants for registration as pharmacists and after hearing may suspend or revoke licenses for cause. In addition its duties are the enforcement of the basic pharmacy law and the laws on narcotics and poisons. Drug stores are licensed and checked for registered personnel; prescription rooms, equipment, and sanitation are also checked. The board issues permits for the operation of drug stores, drug manufacturers and pharmacies in hospitals, and inspects the same.

STATE BOARD OF VOCATIONAL AND ADULT EDUCATION

C. L. GREIBER

President: R. L. Pierce

Executive Officer and State Director: C. L. Greiber

Address: 316 State Office Building, Madison, Wisconsin

Phone: 6-4411, Ext. 758

The board, through its rehabilitation division, provides a variety of services to handicapped citizens of Wisconsin. The program of vocational rehabilitation seeks to meet the needs of handicapped citizens through counseling, training, and medical services which will assist in improving their economic status. Training may be provided through a university, college, or on the job.

STATE DEPARTMENT OF NURSES

Board President: Ruth Coe, R. N.

Board Secretary: Adele G. Stahl, R. N.

Address: 110 Monona Avenue, Madison, Wisconsin

Phone: 6-4411, Ext. 335

RUTH COE, R. N.

This department licenses and re-registers graduate nurses and trained practical nurses—establishes minimum standards for schools of nurses and trained practical nurses; places qualified schools on the accredited list; and initiates rules, regulations, and policies to improve nursing education.

UNIVERSITY HOSPITALS

Superintendent: H. M. Coon, M. D.

Address: 1300 University Avenue, Madison 6, Wisconsin

Phone: 6-6811

H. M. COON, M. D.

The University Hospitals include the Student Infirmary, the Mary Cornelia Bradley Memorial Hospital, the State of Wisconsin General Hospital, the Wisconsin Orthopedic Hospital for Children, and the Cancer Research Hospital. This grouping makes up 900 hospital beds. The University Hospitals are the teaching hospitals of the University of Wisconsin Medical School. The hospitals also provide human services for certain persons who would be unable otherwise to secure such care.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

W. S. MIDDLETON, M. D.

Dean: W. S. Middleton, M. D.

Executive Secretary: H. M. Coon, M. D.

Address: 418 North Randall Avenue, Madison 6, Wisconsin

Phone: 5-3311, Ext. 2554

Its primary function is the training of physicians and ancillary services to medicine; i.e., nurses, medical and x-ray technicians, occupational and physical therapists. Graduate training in preclinical sciences and for the clinical specialists is afforded. Postgraduate opportunities for practicing physicians are coordinated with the State Medical Society of Wisconsin, and members of the faculty are available for professional meetings throughout the state.

UNIVERSITY OF WISCONSIN SCHOOL OF PHARMACY

Dean: A. H. Uhl

Address: 353 Chemistry Bldg., University of Wisconsin, Madison, Wisconsin

Phone: 5-3311, Ext. 2536

A. H. UHL

The major function of the school is to train students in pharmacy, offer postgraduate work to practicing pharmacists, and prepare teachers of pharmacy. It also conducts research in medical science and provides extension services for pharmacists and physicians in the state.

VETERANS ADMINISTRATION REGIONAL OFFICE, MEDICAL DIVISION

Chief Medical Officer: S. E. Sebastian, M. D.

Medical Administrative Officer: Wallace W. MacDonald

Address: 342 North Water Street, Milwaukee 2, Wisconsin

Phone: Broadway 2-6085

S. E. SEBASTIAN, M. D.

Outpatient treatment, medical or dental, including necessary medicines, prosthetic appliances, and other supplies is provided veterans of the military or naval services, who are eligible under laws administered by the Veterans Administration. Home-town medical care is provided through contract with the Wisconsin Veterans Medical Service Agency of the State Medical Society.

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

REV. A. F. BERENS

President: Rev. A. F. Berens, S. J.

Executive Secretary: C. W. Kammeier

Address: 1018 N. Jefferson St., Milwaukee 2, Wisconsin

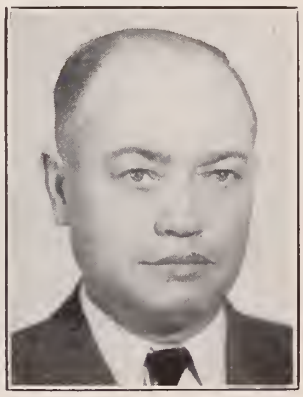
Phone: Broadway 6-5487

This association conducts case finding through tuberculin testing programs, mobile x-ray clinics, and consultation on referred cases; medical social service, including help to patients and families in resolving social, emotional and economic difficulties pertaining to medical recommendations, plans for sanatorium admission regardless of legal residence; rehabilitation; education and research.

WISCONSIN ASSOCIATION OF THE DEAF, STATE SERVICE BUREAU

Director: R. W. Horgen

Address: 312 Woodland Circle, Madison 4, Wisconsin



R. W. HORGEN

The Service Bureau carries on publicity for better understanding of the deaf people and their employment, civic and personal problems; promotes the economic and educational well-being and safeguards the interests of the deaf; serves as an intermediary for deaf individuals or groups in their dealings with various local and state agencies.

WISCONSIN ASSOCIATION FOR THE DISABLED

President, Board of Directors: Clare D. Rejahl

Executive Secretary: Kenneth L. Svee

Address: 119 East Washington Avenue, Madison 3, Wisconsin

Phone: 5-2789

K. L. SVEE

This association provides services for disabled children or adults which are not available through any other sources. Major projects are Camp Wawbeek, a recreational camp for the disabled; Wisconsin Homecrafters Shop, an outlet for the sale of articles made by the homebound; two cerebral palsy evaluation and treatment centers; and a public education service. Through affiliated county units, assistance in medical care, special education, prosthetic equipment, and transportation are provided.

WISCONSIN ASSOCIATION FOR MENTAL HEALTH

MRS. L. C. SENESCALL

President: Mrs. L. C. Senescall

Secretary: Esther H. de Weerdt, Ph. D.

Address: 405 E. Grand Ave., Beloit, Wisconsin

Phone: Gr. 284

The Wisconsin Association for Mental Health is the state member of the organization of the National Association for Mental Health, a voluntary citizens organization. Its present chief responsibility is to find citizens to promote public understanding of the mental health field in their respective communities and to provide reliable information and help for their use.

WISCONSIN ASSOCIATION FOR PUBLIC HEALTH

President: E. R. Krumbiegel, M. D.

Secretary-Treasurer: Ralph Kuhli

Address: 1 West Wilson Street, Madison, Wisconsin

Phone: 6-1411, Ext. 511

E. R. KRUMBIEGEL, M. D.

This organization sponsors an annual state convention which presents national authorities in public health and provides an opportunity for Wisconsin professional public health workers to meet each other and work together in small sectional groups.

WISCONSIN CONFERENCE OF CATHOLIC HOSPITALS

MSGR. E. J. GOEBEL

Advisor to Wisconsin Conference; Director of Archdiocesan Group: Monsignor Edmund J. Goebel, Ph. D.

Executive Secretary: Miss Gertrude M. Gloeckler

Address: 437 West Galena Street, Milwaukee 12, Wisconsin

Phone: Concord 4-0930

This organization coordinates activities of the 56 Catholic hospitals in Wisconsin; serves as a clearing house for medical-moral problems; and establishes criteria for education and in-service training of the nursing and administrative personnel.

WISCONSIN COUNCIL FOR MENTALLY RETARDED CHILDREN

President: Arthur J. Aylward

Recording Secretary: Mrs. Fred Gee

Address: 2718 N. Prospect Avenue, Milwaukee, Wisconsin

Phone: Woodruff 4-0135

This is a voluntary organization to secure appropriations from the legislature for the Southern and Northern Colonies and for other state supported programs for mentally retarded children; to provide them with adequate personnel; to obtain for Wisconsin's mentally retarded children and their parents and guardians all of the rights to which they are entitled; and to assist in the education of the general public as to the causes, care, and needs of mentally retarded children.

WISCONSIN COUNCIL OF SAFETY

President: Myron E. Jolidon

Exec. Secretary-Treasurer: R. W. Gillette

Address: Rm. 234, State Office Building, Madison 2, Wisconsin

Phone: 6-4411, Ext. 451

M. E. JOLIDON

This Council organizes two statewide conferences and three technical clinics each year. Programs include subjects on industrial and public health. It gives advice and assistance to (1) regional groups who organize six regional conferences annually on health and safety, (2) local groups carrying out like programs in 22 active safety councils found in major cities. It publishes a quarterly bulletin, *Wisconsin Safety News*, with circulation of 5,000 copies. It conducts a statewide contest among industrial groups with 25 awards given out. It cooperates with the University of Wisconsin in developing and promoting safety and health training courses and provides a list of qualified safety and health speakers.

WISCONSIN DIABETES ASSOCIATION

President: Maurice Hardgrove, M. D.

Secretary-Treasurer: Karl H. Beck, M. D.

Address: 1411 Wauwatosa Avenue, Wauwatosa, Wisconsin

Phone: Spring 4-0602

MAURICE HARDGROVE, M. D.

It arranges for yearly diabetes week during which there is a concerted effort to have everyone consult his doctor for a urinalysis; education for the physician through scientific literature, speakers and exhibits; education of diabetics for better control of their condition; and promotion of research in diabetes.

WISCONSIN HEART ASSOCIATION

L. R. SCHWEIGER, M. D.

President: Lamont R. Schweiger, M. D.

Executive Director: Grant Larned

Address: 642 North Fifth Street, Milwaukee 3, Wisconsin

Phone: Broadway 1-8716

It conducts a three-phase program consisting of research into the causes and cures of heart disease, education of the medical profession and the lay public, and community service. Research is being carried out at well over a hundred hospitals and medical schools, including Marquette and Wisconsin universities. The results of research are brought to the medical profession by means of four periodicals distributed by the Heart Associations, as well as by cardiology courses and seminars. On a state wide basis there are mobile rheumatic fever clinics which are held anywhere in the state at the request of the county medical societies.

WISCONSIN HOSPITAL ASSOCIATION

President: Franklin D. Carr

Executive Secretary: N. E. Hanshus

Address: 310 Chestnut Street, Eau Claire, Wisconsin

Phone: 2-6611

F. D. CARR

This is a voluntary association to promote the welfare of the public through the development of hospital and outpatient service. It encourages professional education, scientific research activities, and the health education of the public and cooperates with other organizations having similar objectives.

WISCONSIN PUBLIC HEALTH COUNCIL

President: Miss Edith Bangham

Secretary: Mrs. Otto L. Falk

Address: 704 E. Gorham Street, Madison, Wisconsin

Phone: 6–3101

MISS EDITH BANGHAM

The Wisconsin Public Health Council is organized to further public health in Wisconsin, and to promote the establishment of full-time health departments in local communities. The Council is vitally concerned with the development of community health councils which are organized to stimulate interest in programs for the improvement of public health locally.

WISCONSIN STATE DENTAL SOCIETY

E. D. CALKINS, D. D. S.

President: Earle D. Calkins, D. D. S.

Executive Secretary: Kenneth F. Crane

Address: Suite 412, 704 W. Wisconsin Ave., Milwaukee 3, Wisconsin

Phone: Broadway 6–5710

This society encourages the improvement of the health of the public and promotes the art and science of dentistry. To this end it actively sponsors dental health programs and exhibits for lay education, and promotes public health measures. Continuing professional education programs covering the latest advances in dentistry are also an important activity.

WISCONSIN STATE NURSES ASSOCIATION

President: Mrs. Clara Brauer, R. N.

Executive Secretary: Mrs. C. D. Partridge, R. N.

Address: 161 West Wisconsin Avenue, Milwaukee 3, Wisconsin

Phone: Broadway 2–3670

MRS. CLARA BRAUER, R. N.

The organization maintains a center of information for potential recruits to student nursing, and for the general public. To help make nurses better informed in their profession, it conducts institutes for private duty, general and industrial nurses, publishes a *Bulletin* issued four times yearly, and a news letter sent several times a year. Through an economic security program, it helps insure job satisfaction for nurses.

WISCONSIN STATE SCHOOL HEALTH COUNCIL

Chairman: Fred Holt

Executive Secretary: Frank O. Stangel

Address: 1111 N. 10th St., Milwaukee, Wisconsin

Phone: Broadway 1–4341, Ext. 348

FRED HOLT

The Council serves as a continuing policy forming and recommending body for the Wisconsin Cooperative School Health Program which helps the school, home, and community in promoting and preserving the health of each child.

WISCONSIN WELFARE COUNCIL

MRS. DONALD SHEPARD

President: Mrs. Donald Shepard

Executive Secretary: Morris Hursh

Address: 440 Washington Bldg., Madison, Wisconsin

Phone: 5–2663

This Council is a voluntary social-planning organization, organized in 1881, to encourage the development of better health services through the promotion and support of needed state legislation. It sponsors institutes and workshops on a district and state level for the discussion of health problems.

WISCONSIN PHARMACEUTICAL ASSOCIATION

President: Donald Niebuhr

Executive Secretary: Jennings Murphy

Address: 161 W. Wisconsin Ave., Milwaukee 3, Wisconsin

Phone: Marquette 8–4384

DONALD NIEBUHR

A grievance committee has been created to serve the physicians and the public by eliminating illegal and unethical conditions in the practice of pharmacy, when such are found to exist. A professional activities committee has the function of promoting the best possible professional services to the physician and to the public. A public health committee exists to serve the physicians and the local medical societies and county health organizations in their programs of education about cancer, diabetes, heart, tuberculosis, etc.

Dispensing of Drugs by Physicians and their Employees

QUESTIONS regarding the legal implications of dispensing of drugs by physicians or their employees have arisen from time to time. The opinion of the attorney general of the State of Wisconsin, set forth below in its entirety, discusses in clear and simple language the physician's possible legal liabilities, generally, as well as the extent of his and his employee's authority to dispense drugs.

"*Physicians and Surgeons—Pharmacy:* Dispensing of drugs by physician to patient in course of professional treatment is exempt from provisions of ch. 151, the pharmacy law, and no violation of sec. 151.04 (2) or 151.07 (3) Stats., is involved where the particular prescription is delivered to the patient by the office girl who has been directed by the physician to select certain tablets from a designated container and package the same under the general supervision of the physician."

January 29, 1952

Mr. Sylvester H. Dretzka, Secretary
State Board of Pharmacy

"You have asked for our opinion as to the latitude which a physician may grant his office girl in the dispensing of drugs and for purposes of illustration the following factual situation is presented:

> 'The doctor has a stock of drugs on hand. After naming a patient, he orally or in writing instructs his office girl to furnish the patient with certain drugs. The girl selects a container from among several (For example—10 or more varieties of Sulfa tablets), and counts out the number indicated. She then packages and labels the package. The exchange is also completed by her with the patient. This girl, without professional training, prepares the entire transaction which would normally be prepared by a pharmacist as required.'

"We are asked whether this constitutes a violation of secs. 151.04 (2) or 151.07 (3).

"Sec. 151.04 (2) provides:

> '(2) No person shall sell, give away, barter, compound or dispense drugs, medicines or poisons, except paris green, in packages labeled "paris green, poison," nor permit it, in a town, village or city of five hundred or more inhabitants, unless he be a registered pharmacist, nor institute nor conduct a place therefor without a registered pharmacist in charge, except that a registered assistant pharmacist may do so under the personal supervision of a registered pharmacist, and may have charge during the pharmacist's necessary absence, not to exceed ten days. If the inhabitants are less than five hundred, only a registered assistant pharmacist is required.'

"So far as material here an exception to the foregoing provision is contained in sec. 151.04 (3) reading:

> '(3) This shall not interfere with the dispensing of drugs, medicines or other articles by physicians, * * *'

"Sec. 151.07 (3) provides:

> '(3) No person, except a registered pharmacist or a practitioner shall prepare, compound, dispense or prepare for delivery for a patient any dangerous drug.'

"In *State v. Maas*, 246 Wis. 159, 16 N.W. 2d 406, which involved the sale of drugs in a drug store by a clerk who was neither a registered pharmacist nor a registered assistant pharmacist, the court said at p. 165:

> 'The drug business is intimately associated with public health. The legislature has prescribed rules and regulations to protect the public from the mistakes of the untrained. Although the statute may be confusing, and very likely can be made to carry the meaning more clearly by a redrafting, its purpose appears to be the prevention of any but registered pharmacists or assistant registered pharmacists under the personal supervision of registered pharmacists, from selling or compounding drugs.'

"The court in that case had no occasion to consider the statutory exception in favor of physicians quoted above, and of course, this language should be read in the light of the factual situation as presented to the court. Nevertheless the case is significant as enunciating the principle that the drug business is intimately associated with the public health and that the purpose of ch. 151 is to protect the public from the mistakes of the untrained.

"See also *Hoar v. Rasmussen*, 229 Wis. 509, 514, 282 N. W. 652, where the court said:

> 'The circumstances of a pharmacist's or druggist's calling demand the exercise of a high degree of care and skill, such care and skill as an ordinarily prudent person would exercise under those circumstances, the highest degree of care and prudence consistent with the reasonable conduct of the business. The effect of a mistake may be swift and disastrous. There are many cases in which druggists have been held liable for injuries resulting from negligence in filling a prescription or supplying a remedy. * * *' (Citing cases.)

"This same principle of solicitude for the public health in the handling of drugs has been enunciated

many times by the courts. See, for instance, *Marigny v. Dejoie* (La. 1937), 172 So. 808, holding that all persons dealing with poisons, especially druggists, are bound to use the highest degree of care known among practical men to prevent injury from use of poisons.

"The hazard to the public health arising through the sale of drugs by an untrained person is equally great whether there is an absence of personal supervision by a licensed pharmacist or a physician.

"In 3 O.A.G. 555 it was considered that a practicing physician is not authorized to run a drug store without complying with the pharmacy law. In other words the exemption in favor of the physician applies exclusively to the furnishing of drugs prescribed by practicing physicians in the treatment of their own patients and they are not authorized to sell drugs to the general public indiscriminately. It is true that at the time the above opinion was written one exemption read: 'Nothing herein shall interfere with any practicing physician when dispensing his own medicines, or supplying his patient with such articles as may seem to him proper.' However, in 16 O.A.G. 722, after the exemption has been changed to its present form the same view was expressed as in 3 O.A.G. 555 with the observation, 'Since said opinion the wording of the pharmacy law has been somewhat changed on this subject, but for all practical purposes the meaning and the significance is the same.' P. 724.

"It is common knowledge that a physician who furnishes medicines to his own patients does not thereby conduct a 'drug store.' *Medico-Dental Bldg. Co. of Los Angeles v. Horton and Converse* (1942 Dist. Ct. of Appeal, 2nd Dist. Div. 3, Cal.), 124 Pac. 2d 56. Sec. 4031 of the California Code relating to pharmacy reads:

> 'This chapter does not apply to or interfere with anyone, who holds a physician's and surgeon's certificate and who is duly registered as such by the Board of Medical Examiners or the Board of Osteopathic Examiners of this State, with supplying his own patients with such remedies as he may desire if he acts as their physician and is employed by them as such and if he does not keep a pharmacy, open shop or drug store, advertised or otherwise, for the retailing of medicines or poisons.'

"There the exemption is more clearly spelled out than it is in Wisconsin, but there is no reason for believing that the legislative intent is particularly different as has been shown above in the administrative construction given our statute.

"So far as responsibility for the negligent acts of their employees are concerned the pharmacist and the physician stand on pretty much the same footing.

> 'In accordance with the elementary principle that the master who undertakes to perform a service is liable for the negligence of his servant who, in the scope of his employment, is performing the service undertaken, it is well settled that when a person has been injured through the negligence of a druggist's clerk, the druggist is liable.' 17 Am. Jur. 'Drugs and Druggists' Sec. 35.

"See also 28 C.J.S. 'Druggists' p. 517, chap. 9 (c).

"Also it is the established rule that a physician must exercise due care in selecting his assistants, and on the simplest principles of the law, agency, or of master and servant, a physician may be liable for the neglect or fault of his employee or servant. 41 Am. Jur. 'Physicians and Surgeons' Sec. 112.

"Following the theory that the exemption in ch. 151 in favor of the physician was intended to apply exclusively to the furnishing of drugs prescribed by a physician in the treatment of his own patient, or possibly the occasional furnishing of drugs to another physician, it would seem that any carelessness in delegating any part of the dispensing to his subordinate where harm resulted to the public might entail liability on the part of the physician or helper or both. But it nevertheless appears that it was not the purpose of ch. 151 to subject the physician or his helper to the jurisdiction of the board of examiners in pharmacy or to make such individuals criminally liable for the illegal dispensing or sale of drugs incidental to the treatment of a patient.

"However, where the relationship of physician and patient does not exist and a member of the general public applies either to the physician or his helper for the purchase of drugs without a prescription the exemption does not apply, since as above pointed out the exemption was not intended for the purpose of placing the physician in the drug store business but merely to help him to supply drugs to his own patient as an incident to their treatment. We understand, for instance, that certain complaints have been filed with the state medical grievance committee under sec. 147.195 wherein investigators have called at the offices of certain physicians and have been sold dangerous drugs such as phenobarbital by the office girl without any prescription whatsoever. In at least one case the sale was said to have been made by the office girl when the doctor was away on an extended vacation. In instances of that sort it may well be concluded that the physician is virtually operating a drug store without meeting the requirements of sec. 151.02 (9) regulating operation of such stores.

"But where the relationship of physician and patient exists many things may be done by an unlicensed assistant pursuant to direction and supervision of the physician and we will certainly not attempt here to gaze into the crystal ball for the purpose of conjuring up all the hypothetical situations which may arise under such relationship along with the appropriate answers to the problems presented. However, to illustrate the extent of the dele-

gation of important and even dangerous tasks to subordinates mention might be made of the fact that nurses administer anaesthetics, make hypodermic injections and attend to medication of patients pursuant to the physician's directions, and it is immaterial whether the nurse is registered or not except that she may not hold herself out as a registered nurse unless she is registered under ch. 149. *See Nickley v. Eisenberg*, 206 Wis. 265, 239 N.W. 426; 9 O.A.G. 87; 30 O.A.G. 245.

"Moreover there is authority to the effect that where a hospital nurse neglected to read the label on a bottle and inadvertently supplied formalin instead of novocaine requested by the surgeon, the surgeon was not liable unless it could be shown that by exercising ordinary care he could or should have been able to prevent injurious effects. *Hallinan v. Prindle*, 17 Cal. App. 2d 656, 62 Pac. 2d 1075. In this case the surgeon was permitted to introduce evidence of the custom of surgeons to accept from the attending nurse instruments, medicine and drugs without personal examination thereof. It should be stated, however, that there was nothing in the evidence to show that the nurse in this case was the servant, employee or even the agent of the doctor, she being the employee of the hospital.

"In view of the foregoing it is concluded that where a doctor has a stock of drugs on hand, and in the course of treating a patient he instructs his office girl to furnish the patient with certain named tablets which she proceeds to obtain from the container and measure out for the patient, delivering the same to the patient, there is no violation of sec. 151.04 (2) or sec. 151.07 (3) although the doctor may be liable for his own negligence or the negligence of his employee in such case. In any event the physician may not, except by complying with sec. 151.02 (9) either directly or indirectly through his employee engage in what amounts to a drug store business by the dispensing and sale of drugs to the general public where the relationship of physician and patient does not exist between him and the purchaser."

VERNON W. THOMSON
Attorney General

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1953 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Unless otherwise directed, forms for the purpose of referral may be obtained from the Bureau for Handicapped Children, and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined so that plans may be made for the required personnel.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and, if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of this fact.

Lancaster	December 30
Ashland	February 11, 12
Manitowoc	February 19, 20
Marinette	February 25
Kenosha	March 4, 5
Racine	March 12, 13
Green Bay	March 19, 20
Eau Claire	March 26, 27
Wausau	April 1, 2
Sheboygan	April 16, 17
La Crosse	April 21, 22, 23, 24
Superior	April 29, 30
Appleton	May 7, 8
Chippewa Falls	May 21, 22
Fond du Lac	May 28, 29
Rhinelander	June 3

Inquiries concerning these clinics may be addressed to the Bureau for Handicapped Children, Room 146 North, State Capitol, Madison 2, Wisconsin.

The Psychiatrist in Court*

By HANS H. REESE, M. D. and EDWARD R. HODGSON, M. D.
Madison

THE use of psychiatrists by courts of law is made necessary because:

1. Mental problems at times underlie criminal acts.

2. Legal commitment procedures are often needed to insure proper care for persons with mental illness and to protect the public.

3. The testamentary capacity of persons of advanced age is established principally by medical opinion.

4. The disposition of sexual psychopaths by statute requires psychiatric evaluation.

With the mounting awareness generally of these problems and their greater incidence, psychiatrists find themselves drawn into an ever increasing number of medico-legal situations.

It is quite possible that the demands placed upon psychiatrists to fulfill these duties in court are beyond the present knowledge of human psychology, but the men of law and science must join their talents to formulate scientific proof in court, *i.e.*, jurisprudential and evidentiary efforts to determine the basic questions of facts by the most trustworthy methods intelligible to law, medicine, and lay juries. Clinical forensic medicine embraces all varieties of medical practice which may yield evidence relevant to litigated issues by using tests and methods currently employed in diagnosing and healing patients. In court a physician must be impartial, and in the clinic he must be qualified to investigate the physical condition and the mental status of a party litigant. He must be clear and simple in his descriptive testimony and be able to stand collateral cross-examinations, even on subjects on which he is not an expert. A transcript of any medical testimony in medico-legal cases, if questioned or criticized in court, should be submitted to a scientific surveillance committee of our State Medical Society, considering, however, honest differences of opinion and varying clinical judgment.

We are fully aware that scientific proof is not available for all medico-legal problems. This is especially true in homicide cases where the plea of insanity is raised too frequently by the defense. A physician in court is called upon to establish whether at the time of committing the criminal act the party accused was laboring under a defect of reason from disease of the mind so as not to know the nature and quality of the act he was doing; or, if he did know it, whether he knew he was doing what was wrong. These decisions are difficult and often impossible for the physician when he is asked to answer with a categorical "yes" or "no," or is required to conform to the pernicious hypothetical question system.

In our opinion, mental disease itself is rarely the sole cause of criminality, though it predisposes to violent reactions and propels toward criminal behavior. This statement can be documented by experiences in our psychiatric hospitals where we have observed attacks by patients on hospital personnel and on other patients, based on the delusions and confused thinking of the mentally ill individuals. On the other hand, let us consider the case of an epileptic who, during his postictal confusion and disorientation and on being in a "frenzied state," commits a violent crime "without insight or power to abstain." During this time his sensorium is radically deranged, but he is still able to walk and perform acts as in a dream. This unfortunate perpetrator of the assault at the time of his misconduct is both unable "to appreciate the nature and quality of his act and to distinguish right from wrong"; thus, the defense is fortified to inject with justification a plea of temporary insanity. But what assurance do we have that even with the best therapy and constant supervision a crime is not repeated? Therefore, a decision of commitment is under consideration, though we know from experience that a similar criminal act rarely occurs. We recommend in these instances parole, with frequent electroencephalographic studies and well supervised drug therapy. Such epileptic persons, presenting at times major personality disorganizations, are not responsible for a criminal act during the psychosis. In these cases a psychosis must be recognized, since the concept of the psychosis in court proceedings is primarily of legal, rather than of medical, importance, and it usually carries with it denotations and connotations of incompetence at law, which means insanity in the statutes. It must be pointed out, however, that today very few sufferers from epilepsy manifest such transient, but truly psychotic, episodes.

Psychoses are major personality disorganizations, characterized by poor contact with or appreciation of reality, disturbed ethical and social relations, and progressively failing ability, in many persons, to maintain a stable relationship with their environment. Psychoses may or may not be accompanied by signs of organic brain disease, by defects in the intellectual functions, by emotional deterioration, or by accessory symptoms such as hallucinations or delusions. In contrast the psychoneuroses are personality maladaptations which do not disrupt the relation with reality and with the environment suffi-

*Read at the "Institute on Laboratory and Scientific Methods of Judicial Proof," October 31, 1951, Madison, Wisconsin, University of Wisconsin.

ciently to enable a victim of psychoneuroses to be considered insane by law, even if he has criminally offended our social and moral codes. Psychoneuroses are reactions of maladaptation and defense against inner, often unconscious, conflicts and feelings.

The clinical investigation of a court-referred patient includes a detailed personal and social history, not alone from the defendant but also from reliable relatives and from members of his community, and a physical examination with all the known modern auxiliary technics and laboratory tests. Certain psychologic studies may be necessary, according to the case. In common use are the Bellevue–Wechsler test, primarily designed to rate the patient's intellectual endowment against that of the general population, and the Rorschach (ink blot) test, which often discloses basic unconscious problems leading to whatever emotional or personality deviations the patient may demonstrate. A complete discussion of the findings with all examiners concerned is very desirable. Reports of behavior and conduct, as observed by the nursing staff while the patient is under detention and observation, are of aid especially in the detection of malingering. Inaccessible patients, mute or non-productive for whatever reason, may be submitted to sodium amytal analysis, especially when the contents of the material of the analysis are presented to the patient in the follow-up for elaboration and verification. We are not advocating the use of sodium amytal interviews because it is a "truth serum." First, there is no "truth serum," and second, unfortunately fallacious lay opinions have been publicized in the press. In our opinion, its use is merely to elicit facts from patients unable or refusing to verbalize, regardless of the reason. We realize well that any information obtained under the drug may not be admissible in court proceedings.

A problem at present arousing a great deal of attention in this country is that of the sex offender or sex criminal. The widespread anxiety has been stimulated by an apparent increase in sex crimes, an increase not substantiated by valid statistical reports, and more especially by the detailed and often gruesome publicity in the press about sex maniacs and sex crimes. A great amount of experimental study to prevent, to recognize, and to handle the sexual deviates effectively is under medical attention in the interest of public security. The so-called sexual degenerate or psychopath cannot be sharply defined either in law or administrative practice, nor do we as physicians have any consistent criteria for the classification of these aggressive and perverted sex offenders.

A distinct group of sex-deviated habitual offenders who are not psychotic but are distorted in their emotional and volitional responses engage in repetitive, dangerous, and compulsive sex crimes. These offenders should be cared for in special "institutions for psychopaths," even though the outlook for recovery is indeed unsatisfactory. Sexual psychopathy incorporates a wide variety of sexual offenses, and various clinical subdivisions are included. It is a known fact that many "first" sex offenders do not recidivate, and that those who do tend to repeat sex offenses do not necessarily develop into the dangerous forms of criminal sex behavior. In quite a different class belong those aggressive and brutal sex deviates with obviously serious psychiatric aberrations. In this group belong the rapists, the homosexuals, who direct their attention constantly to children, and the rather rare cases whose sexual activities are accompanied by the need to commit bodily harm and even death on the partner. Many of the states now have specific statutes defining psychopathic sexual behavior and providing for dispositions for victims of various sex aberrations (hospital study, detention in penal institutions, and occasionally outpatient psychiatric treatment).*

In contrast with the serious type of sex offenders are those who, at least from the psychiatric viewpoint, are not really a menace to the community but are only and often a nuisance problem. These include the voyeurs (window peepers), the exhibitionists, and the fetish peddlers. These people are suffering from an obsessive-compulsive type of neurotic behavior, and need psychotherapeutic help, but they are not benefited by incarceration in either penal or mental institutions unless psychotherapy is afforded them, and even with the best treatment they are difficult to cure.

The problem of homosexuality is very complex. It is assumed today that homosexuality is a reactive symptom of many possible underlying causes, psychologic, constitutional, physiologic. The behavior deviation is manifested in various ways. Some homosexuals are directed for the satisfaction of their sexual desires and drives only toward younger members of their own sex, others only toward older members. Some are attracted only toward people of an entirely different economic or social level, usually lower than their own; others direct their contacts only toward people of specific body types, or toward those with particular physical or personality characteristics. Some individuals show a homosexual inclination only under the influence of alcohol, when the emotional control mechanism is grossly altered. Running through all types as listed are the bisexuals, indiscriminately directed toward both sexes, either at the same or different times. In the presence of such a variety of manifestations of homosexuality, and in the absence of clear-cut generally accepted explanations for these aberrations, it seems best in this discussion to segregate those persons who may be considered problems of public concern. These are the individuals whose sexual drives are toward minors and those who become nuisances because of their provocative behavior in public places to attract the attention of others who may have similar proclivities. The other homo-

*This extremely difficult subject, as it has been handled in the various states, is beyond an adequate discussion here. Any interested person is referred to a recent book, "Sex and the Law," by Judge Morris Ploscowe (New York, Prentice Hall, 1951).

sexuals, and they are fortunately in the majority, are not criminal menaces to society. Occasionally homosexuality is seen in people approaching senility and in those who are beginning to lose their former ordinary moralistic controls and inhibition facilities.

In statutory rape, sexual intercourse carried on with one below the age of consent, we strongly recommend examination of both parties, because often the sexually delinquent minor has been the tempter and aggressor in the act and is commonly a more important psychiatric problem than the non-psychotic offender.

In our opinion, if the label of "sexual psychopathy" is to be used, the following criteria must be fulfilled: (1) The act must have been an aggressive one against minors; (2) The act must have been an aggressive one against an adult without that person's consent or with intent to do bodily harm in addition to the sexual attack; (3) The tendency to such criminal sexual acts must be repetitive, not a single isolated offense in the life of the accused; (4) It must not be a mutual agreement of "abnormal" relationship between adults; (5) The act must not have been carried out under the effect of alcohol or drugs; (6) It must not have been done by a mentally ill or feeble-minded person.

In order to establish these criteria, it is necessary to request complete psychiatric evaluations of each young or adult offender with subsequent attempts to rehabilitate and to re-establish social standing for him in the community.

A frequent and most difficult problem in our courts is the "psychiatric ills." What is a mentally ill person? Medically, it is one who in his symptoms and past history fits the concept of being psychotic and incompetent. Legally, it is one who, by reason of unsoundness of mind, is incapable of living normally or of managing his affairs or of conforming in relationship to others and to lawful orders if permitted to go at large, or one who is in such condition of mind or body as to be a necessary subject for care and treatment in a hospital for the mentally ill. The word "insane" as applying to state hospitals and court commitments has been abolished, and the term "mentally ill" has been substituted. In this connection, we urge that courts accept the testimony of legally appointed medical examiners regarding the presence or absence of mental illness in a patient being considered for commitment for mental disease. It is not always possible to present or to demonstrate to the judge at the time of a court hearing all the symptoms that prove the presence of a mental disease. Therefore, a person unquestionably suffering from a serious mental aberration is often released from all custody or necessity of treatment because the court was not convinced by the patient's behavior, statements, or attitudes that a mental illness was present. Conversely, we physicians are not able to answer the often asked question: Is a person totally and permanently recovered after having been legally committed because of mental illness? This is due partly to the unpredictable tendency of some diseases to recur, and partly to the need for long observation of the individual in question. Such a final release decision should be rendered to the court only by the staff opinion of a psychiatric hospital after a long period of satisfactory observation. The above question becomes especially pertinent when previous criminal offenses have complicated the psychosis. In addition to these problems, a much more frequent difficulty confronts physicians and psychiatrists in court when they are expected to differentiate between insanity in the legal sense and mental illness in the medical sense. Our testimony is often limited to "yes" or "no" answers without our being permitted to present our findings and diagnosis in greater detail.

Psychiatry today is used too often as a defense, though guilt or innocence is not proved and the controlled evidence not presented in an open court. We recommend that our Wisconsin courts adopt the following procedure: (1) Appoint a panel of two psychiatrists and one physician in general practice who will be available in a given criminal case for explanation and discussion to both sides after completion of its studies; (2) Make available to the psychiatrists and physicians testifying in courts for the prosecution or defense all information to avoid possible partiality; (3) Set and pay the fee by a state schedule. To remove much of the unfavorable impression of today's court psychiatry in the law mind, we suggest that the insanity issue at the time of trial be abolished. The individual should be tried for the offense, and thereafter medical opinion used as a means of disposal. The psychiatric issues as a means of defense in a criminal court should be discarded.

Another important function of the psychiatrists in court proceedings is in matters of contested wills in reference to the competency or incompetency of the testator, and whether or not the testator possessed the power of disposing, *i.e.*, the mental capacity. The fact that he was of sound mind and memory must be very clearly established by witnesses and most preferably by the physician who has or had supervised the health of the testator previously. Testamentary capacity does not demand a "perfect mental state," since minor delusions are not inconsistent with full awareness of the possessions of the testator and of his desire to dispose of them according to his wish and will. However, this matter must be settled for each case, since theoretical questions are impossible to answer. The same applies to the questions of undue influence, overt persuasion, or coercion in the making of a will. These facts must be established from all information available pertaining to the circumstances of the signing of the will. It is of major and controlling importance to establish whether or not a testator knew what he was doing and if he understood the substance of his will and the scope of his disposition. Without having at his disposal every circumstantial fact about the testator, a physician should refuse to offer an opinion in court as to competency.

The Physician's Will and Estate

EVERY physician owes the duty to his wife and family to plan the disposition of the estate which he has built up during his years of practice. It also includes certain transactions which take effect during his lifetime. Primarily such planning deals with problems regarding the disposition of his estate at the time of death.

The need and desirability of planning, including the execution of a proper will, is discussed in this article. Briefly such planning is necessary (1) to prevent the operation of the intestacy laws, (2) to eliminate guardianship over the property of minors, (3) to prevent substantial depletion of the estate by ignoring tax saving devices, (4) to provide expert investment and management of the estate after the physician's death, and (5) to take care of any specific bequests which a physician may wish to make. Each of these is discussed more fully in the paragraphs which follow. In addition, care must be exercised that sufficient liquid assets are available to the estate for administrative costs and death taxes so as to avoid forced sale of property.

Some physicians may feel that their estate is too small to bother about planning its disposition. Most physicians have a small bank account, a few bonds or securities, household furniture, an automobile, and life insurance policies. Such an estate probably amounts to several thousand dollars. Many also own an equity in a home. Many of the reasons set forth in this article pointing up the necessity of a will apply just as well to the small estate as to the larger one. Furthermore, in the small estate, every dollar counts in so far as the surviving widow and children are concerned and care should be taken that these few dollars do the most adequate job possible.

When the physician arrives at the attorney's office to discuss his estate planning and will drafting, he should be prepared to present to the attorney a complete itemization of all of the assets owned by himself and members of his family, indicating the ownership of each asset, their original cost, and approximate present value. In addition, his life insurance policies should be left with the attorney for his examination and recommendations regarding settlement options, qualification under the marital deduction, and possible changes in beneficiary designations. In this connection it might be wise to arrange for the attorney to discuss the life insurance policies with the physician's life insurance agent. While life insurance generally passes independently of the physician's will, it is nevertheless included in the assets which become available upon a physician's death and must be included in the physician's estate for death tax purposes.

The Joint Tenancy Trap

Many individuals are under the mistaken notion that the placing of one's property in joint tenancy with one's wife is a substitute for a will. As has been so often said, joint tenancy is a substitute for a will in about the same sense as a size 34 suit will fit all men. It will fit some men but not others. In the first place, joint tenancy always makes imperative the execution of wills by both husband and wife. A joint tenancy always involves a gamble as to who dies first. In many cases husband and wife may die within a short time of each other. Therefore, in order to insure the distribution of the estate upon the death of the surviving joint tenant in accordance with the desires of the parties, wills for both husband and wife become necessary.

Probably the greatest danger of joint tenancy lies in its tax implications, both death tax and income tax. It is commonly thought that when a person dies holding property in joint tenancy that only one-half the value of such property is included in the estate for inheritance and estate tax computations. This happens to be true for Wisconsin inheritance tax purposes. It is not true, however, for federal tax purposes. The federal tax authorities have ruled that regardless of whether a valid gift was made during lifetime of a joint tenancy interest and regardless of whether a gift tax was paid, the entire value of the joint property will be included in the taxable estate of the person who furnished the money for the acquisition of the property. In most cases, this will mean the physician himself.

This problem arises, of course, only where the estate is subject to federal estate taxes, namely an estate in excess of $60,000. Those physicians whose estates are presently less than this amount are not, of course, faced with the problem. Certainly, however, most physicians can anticipate accumulating substantially more than this amount during their lifetime, and therefore should bear this in mind when acquiring property of any type.

Income taxwise, the penalties of joint tenancy can be even greater. Again the penalty is limited to federal income tax as distinguished from Wisconsin income tax. For federal income tax purposes the gain on property sold by a surviving joint tenant is measured by the difference between selling price and its *original cost*. Valuation of the property for estate purposes has no bearing whatsoever upon the profit or gain for income tax purposes. As a result of the inflation which has occurred during the past 10 years, most assets have at least doubled in value. Therefore the profit from the sale of assets acquired at the beginning of this 10 year period will be substantial and would subject the widow to needless federal income taxes.

Furthermore, even in the case of those physicians who are acquiring property at today's high prices, it is strongly recommended that the property be not acquired in joint tenancy, since the inflationary tendencies may continue in the future. At any rate no

advantage is gained by holding property in joint tenancy during deflationary times.

It is recommended that physicians hold their property either in their own name individually or in the name of their wife individually, or as tenants in common. The term "tenants in common" is distinguished from "joint tenants" in that property held as tenants in common passes by will or by operation of the intestacy laws, whereas joint property passes independently to the surviving joint tenant. In so far as the federal tax laws are concerned a tenant in common suffers no penalty.

In the case of those physicians who presently hold property in joint tenancy, it is urged that they give strong consideration to changing ownership of the property from themselves and their wives as joint tenants to themselves and their wives as tenants in common. This can be done without incurring additional gift tax liability.

Prevention of Intestacy Law Operation

In the absence of a will, the intestacy laws will govern the distribution of a person's estate. In Wisconsin, this means:

1. *If widow and two or more children survive,* one-third of the real and personal property passes to the widow and the remaining two-thirds is divided equally among the children. Where the deceased person owned a homestead at the time of his death, the widow has the right to use it until her death or remarriage. This homestead right is in addition to the one-third share which the widow takes outright.

2. *If widow and one child survive,* the widow again has the right to use the homestead until her death or remarriage. In addition, the widow is entitled to take one-half instead of one-third of the personal property. In so far as real property is concerned her share remains at one-third. The surviving child takes therefore one-half of the personal property and two-thirds of the real property and the remainder interest in the homestead.

3. *If widow alone survives,* and no issue of any deceased children survive, the entire estate passes to the surviving wife.

4. *If children, but no widow, survive,* the entire estate passes in equal shares to surviving children and issue of deceased children.

Certainly in the case of a young physician, the distribution in accordance with the Wisconsin intestacy laws, placing ownership of at least one-half of the estate in his children, would work a definite financial hardship on his widow. It would seem that in most cases the bulk of a young physician's estate should be left to his widow so as to insure to her the greatest financial means and security during the years when she must take care not only of her own support but also that of her fatherless minor children. It is true that if property comes into a minor's possession that the income therefrom and the principal amount if needed can be used for the support of the minor child. As is pointed out, however, in this article under the heading "Elimination of Guardianship" the use of such funds is fraught with many complications, leading many observers to consider such use of minor's funds more theoretical than practical.

In this age of automobile and airplane travel, there is always the chance that husband and wife may be killed in a common disaster. In this case, the physician's estate should benefit his minor children. However, even in this situation guardianship should be avoided and in most cases a trust presents a more satisfactory and flexible solution to the problem. Again a will is necessary because such a trust cannot be created otherwise than by will. This is discussed more fully under the heading "Elimination of Guardianship."

In the case of physicians who no longer have minor children some situations might present themselves in which distribution in accordance with the intestacy laws would carry out the testator's intentions. In most cases, however, his wishes to provide first for his widow veto such a method of distribution. Furthermore, a physician who no longer has minor children is generally middle-aged or more and has accumulated more than an average estate. Such a physician will need a will, if for no other reason than to prevent death taxes from materially reducing his plans and intentions for his widow and adult children following his death. It is possible, through a properly drawn will, to sharply reduce taxes and at the same time carry out substantially the testator's desires and intentions regarding his wife and children and other objects of his planning.

A physician whose intent, in so far as the distribution of his estate is concerned, coincides with the intestacy law of descent is the exception rather than the rule. This is true of young, middle-aged, or old physicians.

Elimination of Guardianship

Care should be taken to avoid the placing of property outright in the name of a minor. In some cases, it is highly desirable to grant ownership rights in property to minors. In those cases, however, serious consideration should be given to the trust device of ownership during the minority of the child.

In all cases where property descends to minors under the intestacy laws, it does so absolutely and in the name of the minor outright. Inasmuch as the law presumes the inability of minors to manage and protect their property, a guardian subject to court direction must be appointed. In effect, another estate proceeding is commenced in the county court. The widow may be appointed guardian of her own children, but she must provide a surety bond and pay the premium. Furthermore, an annual accounting must be made to the county court.

None of the principal amount of the minor's estate can be used by the widow or other guardian without first getting permission from the court. This means that every time the widow wishes to use a portion of the minor's estate, petitions and court

orders must be prepared and presented to the court, thus entailing the employment of an attorney.

Furthermore, no portion of one minor's estate can be used for the benefit of another minor child. There are situations, for example, serious and prolonged illness, where from the widow's standpoint this might be desirable. In fact, it would undoubtedly have been the wish of the deceased husband that the wife use her own judgment in apportioning and using the principal in accordance with the needs of the several children.

Power of the guardian to invest minors' funds is strictly limited to low income producing securities. In effect, the majority of the investment is limited to government securities. Not only is the interest rate low, but government securities are fixed in amount and cannot, therefore, keep pace with inflation.

In all cases where it is desirable to have property pass to minor children, it is strongly recommended that trusts be created by will. Properly drawn trusts can give to the trustee discretionary power to use both income and principal for the minor's welfare. In addition, a "sprinkler" trust can be created, vesting in the trustee power to apportion and use principal and income for the several children in accordance with their varying needs.

A trust can also be so drawn as to give the trustee power to invest in preferred and common stocks, thus providing greater income and greater capital gain possibilities.

A guardianship ceases when the minor attains the age of 21 years. Oftentimes it may be advisable to withhold payment until the child has reached a more mature age. This can be done only through the trust device.

Tax Savings Devices

If the physician's estate, including life insurance and the entire amount of joint property, exceeds $60,000, considerable death tax savings can be effected by proper planning, without substantially disturbing his desires and intentions regarding his wife and children and other objects of his bounty.

Martial Deduction. The Revenue Act of 1948 introduced the marital deduction concept into the field of estate planning. It applies only to the federal estate tax and has no bearing whatsoever upon Wisconsin inheritance tax. In effect it provides that a person may leave to his surviving spouse one-half of his property, including joint property and life insurance, tax free. The remaining one-half is considered the decedent's estate for federal estate tax purposes. From this one-half is subtracted the specific exemption of $60,000. The balance is subject to tax.

For example, a net estate of $120,000 will pay no estate tax if the marital deduction is utilized, since the first $60,000 is tax free under the marital deduction and the specific $60,000 exemption offsets entirely the $60,000 remainder of the estate. If the marital deduction is not used, the tax on the estate of $120,000 is $9,500.

If the net amount of the decedent's estate is $200,000, the difference in tax payable is $27,900.

The entire estate can be given to the widow. Only one-half is eligible, however, for qualification under the marital deduction.

The portion of an estate which passes to the wife under the marital deduction will, of course, be subjected to tax upon the death of the wife, assuming her estate amounts to more than $60,000. The question therefore presents itself whether it would not be wise to leave the entire estate in trust, giving the wife the income therefrom during her life and paying the principal to the children upon her death. However, assuming the marital deduction is used, the combined taxes on the two estates (husband's and wife's) are still substantially less than the tax would be if computed on the entire estate of the husband. The answer is therefore no.

This is so because tax rates become progessively higher as the size of the estate increases. If the estate can be split into two smaller portions (as is done when the marital deduction is used) two $60,000 exemptions are made available. Also the higher tax rates are avoided because the lower tax rates are used twice in computing the taxes on the combined estates.

Much of this saving, due to utilization of the lower tax rates, will be lost, however, upon the death of the wife in those cases where the wife has a substantial estate in her own right.

Because of tax savings possible in most cases through use of the marital deduction, common disaster provisions in wills are also discouraged.

Three methods may be used to take advantage of the marital deduction. They are (1) an outright bequest to the wife; (2) a trust, all the income of which is payable to the wife for life and the principal payable to her estate; and (3) a trust, the income of which is payable to the wife for life together with a right in the wife to appoint the principal as she may choose during her life or by her will.

Most property, including life insurance and joint property, can be used to qualify under the marital deduction.

In most estate plans, substantial savings can result through use of the marital deduction. Great care must be exercised by the drafter of the will that the technical requirements of the Internal Revenue Code are met when attempting to qualify property under the marital deduction. If life insurance is sought to be qualified under the martial deduction, the settlement options must be carefully worded.

Saving the Second Tax. If the entire estate of the husband is given to the wife, an estate tax will be payable on the entire amount so inherited at the time of her death. In effect, this means that as to the one-half portion of the husband's estate which did not qualify under the marital deduction two

estate taxes will be paid—one at the time of the husband's death and the other upon the wife's death.

It is therefore recommended that the husband strongly consider giving to his wife the marital deduction share of his estate, and placing the remaining one-half in a separate trust, the income of which can be paid either to the wife for her life or accumulated for, or distributed to, their children in the discretion of the trustee. In either event, the principal of such trust should be paid over to the children upon the death of the wife or on their attaining a certain age. In this way, a tax will be paid on this portion of the estate only in the husband's estate, none being due at the time of the wife's death, since she had no interest in this portion subject to tax.

This tax saving device applies to Wisconsin inheritance tax as well as federal estate tax.

It might be well to point out here another objection to holding property in joint tenancy. Since such property passes independent of will, it can never escape the second tax unless it be included in the property making up the marital deduction.

Income Tax Savings By Creation of Second Trust for Children. In those cases where the estate is sufficiently large so as to enable the wife to maintain herself adequately from the income and principal of the marital deduction share, substantial annual income tax savings can result by splitting the non-marital deduction one-half of the estate into separate trusts for each child. In this way the income from such trusts will not be taxed, at top income tax rates, to the widow, but will be taxed as several separate entities, each utilizing the lowest possible income tax rates.

In addition, where the children have independent incomes, savings can result by giving the trustee discretion as to whether the income shall be distributed to the children. This is accomplished by retaining in the trust that income which, if distributed to the child, would place him in a higher income tax bracket than would be paid by the trust if not distributed.

Income Tax Savings by Electing Life Insurance Installment Option. When planning disposition of your estate consideration should be given whether to have the life insurance proceeds paid to the beneficiary in installments over a period of time. Included in the installments paid by the insurance company is interest. The tax authorities have held that none of the installments, including the interest, are subject to income tax. Over a period of years the amount of interest received free from income tax will be substantial. If, on the other hand, the insurance proceeds are paid in a lump sum and then invested by the beneficiary, the income therefrom will annually be subject to income tax.

It should be very carefully considered, however, whether the receipt of tax free income is not overshadowed by the fact that the rate of return paid by insurance is probably less than can be earned by a competent trustee. Furthermore, insurance installments, being a fixed obligation, cannot rise in value as trust property can, should inflation continue.

Gifts During Lifetime. By making gifts of portions of your estate during your lifetime, it is possible to avoid paying any federal transfer tax. The transfer may be subject in part to a Wisconsin gift tax, but the savings in federal estate tax far outshadow the small Wisconsin tax.

In effect, the federal tax laws allow a husband to give away tax free a basic amount of $60,000 during his lifetime. *In addition,* he may annually give away $6,000 to *each donee* without federal gift tax liability. These amounts are conditioned upon either the gift being to the wife or the wife consenting to the gift. If either of these conditions are not met, the amounts are $30,000 and $3,000 respectively.

Problems may arise where the physician seeks to make gifts to his minor children. The obstacles are not insurmountable. It will suffice to point out in this discussion that should such gifts be contemplated, competent counsel should be sought.

It is in the field of making lifetime gifts that the greatest savings of transfer taxes can be accomplished. Each physician of some means should give serious thought to this possibility.

Not to be overlooked when considering the possibility of lifetime gifts is the possible income tax saving. Since ownership of the property made the subject of the gift is no longer in the physician, the income will no longer be taxed to him but to the recipient. Inasmuch as the recipient will probably be in a lower tax bracket than the physician making the gift, savings will result. Furthermore, if substantial gifts to children are contemplated, the income will be divided into separate tax entities, each being able to use the lowest rates as contrasted with the fact that the income would be taxed at the top tax bracket in the physician's return were it still his income.

Specific Bequests

A will is necessary in every case in which the physician wishes to provide specifically for a person or institution other than his wife and children. For example, if the physician wishes to leave a gift to charity or to a faithful employee, such bequest can be made only by a provision in a will.

A word of caution should be given regarding gifts to charities. Care should be exercised that the exact legal name of the charity is used, and the use which the charity is to make of the bequest, if any special one is desired, should be carefully spelled out.

Expert Investment and Management of Estate

In the absence of a will, or in a will which provides that all of the property is payable outright to the wife or children, the property undoubtedly will not be as well managed or invested as was the case during the physician's life. It is generally recognized that the average widow is not equipped by

training, experience, or temperament to be a shrewd investor or manager of property.

Where the amount of the estate is sizable, serious consideraion should be given to placing the bulk of the estate in one or more trusts. Of course, the trustee should be carefully chosen so as to secure for the physician's wife and children expert management and investment. Many of the banks in the larger cities throughout the state have trust departments employing full time personnel, trained in and doing nothing but the management and investment of trust estates. The average physician would do well to discuss the matter, including costs, with his local or nearby trust company.

Estate planning is in essence an effort to make equitable and prudent disposition of whatever property a physician has been able to acquire. It is one of the most important pieces of planning that a physician or other person does. It calls for competent and sympathetic advisors. At the very least he will need an insurance counsellor and an attorney. If his affairs are large enough to warrant it, and in particular if he has to consider alternative courses of action, he will also need the assistance of a professional accountant, an investment counsellor and an experienced trust officer, all working as a team.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 32 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	5:45 p.m.
WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	11:15 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Signing of Death Certificate If No Attending Physician

QUOTED below is an opinion of the attorney general of the State of Wisconsin which clarifies the position of the physician, coroner, and local registrar regarding death certificates in the case where no physician was in attendance. In effect it states that the person desiring to dispose of a body must employ a physician to investigate the cause of death so as to enable the physician to prepare a death certificate.

"*Vital Statistics—Death Certificate:* If there has been no inquest and the physician called for the purpose refuses to sign death certificate (for lack of sufficient information), person desiring to dispose of body has responsibility of procuring a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., and cost of investigating cause of death is necessary part of burial expense. 29 O.A.G. 470 followed.

"Coroner is not authorized to sign death certificate under sec. 69.41, Stats., unless there has been an inquest. But if there has been an autopsy under sec. 366.121, the autopsy surgeon may sign the death certificate.

"Local registrar may not sign death certificate under sec. 69.40, Stats., merely because physician refuses to do so for lack of sufficient information. He may do so only if no physician can be obtained early enough."

December 7, 1951

Dr. Carl N. Neupert
State Health Officer
State Board of Health

"You have requested an opinion with reference to the preparation of death certificates in cases where no physician was in attendance prior to death and a physician called for the purpose refuses to make a death certificate. You ask three specific questions:

> '1. Who should be held responsible for filling out and signing the death certificate in cases where the physician refuses to sign and where the coroner has not held an inquest?'
>
> '2. Is the coroner authorized to sign a death certificate without having held an inquest?'
>
> '3. Is the local registrar authorized to sign a death certificate when a physician refuses to do so or where a coroner is not authorized to sign the death certificate?'

"The answer to your first question is that the person desiring to dispose of the body by burial or cremation is obliged to obtain a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., which provides as follows:

> 'The body of any person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of, until a permit for burial or removal is issued, and no burial or removal permit shall be issued until a complete and satisfactory certificate of the death has been filed as herein provided.'

"If a physician's services can be obtained the local registrar is without authority to sign the death certificate. The applicable statutes are secs. 69.39 and 69.40 which provide as follows:

> '69.39 In case of death without the attendance of a physician, or if the certificate of the attending physician cannot be obtained early enough for the purpose, any physician employed for the purpose shall upon the request of the local registrar or his deputy, make such certificate as is required of the attending physician.'
>
> '69.40 When a physician cannot be obtained early enough and *only in such case*, the local registrar is authorized to insert the facts relative to the cause of death, from the statements of relatives or other competent persons, and the permit for burial shall be issued upon such information.'

"As pointed out in the opinion in 29 O.A.G. 470, the local registrar has no authority to employ a physician to investigate the cause of death and the law contemplates that the person desiring to procure the disposition of the body must retain a physician to investigate the cause of death, performing an autopsy if necessary, and pay the physician's fee for that service. Such fee is a necessary part of the burial expense.

"The answer to your second question is that the coroner is not authorized to sign the death certificate unless an inquest has been held. Sec. 69.41, Stats., is the applicable statute and provides as follows:

> 'Any coroner *who holds an inquest* on the body of any deceased person required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall furnish such information as may be required by the state registrar to classify the death.'

"The cases in which a coroner is authorized to hold an inquest are limited by sec. 366.01, Stats. However, even in such cases there may be situations where no inquest is held but nevertheless an autopsy may have been conducted as authorized by sec. 366.121, Stats. In that case the autopsy surgeon could properly make the death certificate, but the coroner could not since his statutory authority is limited to cases where an inquest has been held.

"The answer to your third question is that under sec. 69.40 the only case in which the local registrar

is authorized to sign the death certificate is "when a physician cannot be obtained early enough." Clearly the case is excluded when a physician can be obtained early enough but refuses to make a death certificate because of lack of information. In that case the person desiring to dispose of the body must arrange for the physician to make the necessary investigation of the cause of death and pay him for such investigation, as set forth in the answer to your first question."

VERNON W. THOMSON
Attorney General

Code of Necropsy Procedure*

Preamble

IN ORDER to maintain a closer relationship between the groups involved, the following points should be considered, and, to the extent possible, efforts made by all parties concerned to help each other in their respective fields:

(a) All agree that postmortem examination by a pathologist is desirable; first, to provide reliable recorded information concerning the cause of death and the nature of the various disease processes; second, to confirm or amend the opinions formed by the physicians during the life of the patient, so that they may serve the next patient with greater confidence and skill; third, to reveal to the physicians continually the physical changes in the interior of the body which are associated with disordered behavior during life; and fourth, to provide for the advance of human knowledge concerning the nature of disease in general. It is well recognized that the practice of postmortem examination in a hospital exercises a constant influence to improve the service and to correct serious deficiencies, as well as to improve diagnosis and prevent disease.

(b) All necropsies are to be performed by a licensed physician, preferably a pathologist, because in the performance of a necropsy the pathologist assumes certain responsibilities to the funeral director and to the family regarding the condition of the body.

(c) The fact that the deceased human body is subject to immediate decomposition and postmortem changes in the skin, face, hands, and other tissue (e.g., postmortem staining, collapse of circulatory system) changes which cannot be effaced by the embalmer, it follows that immediate attention should be given to the body so as to prevent or retard as many physical and chemical changes as possible. Refrigeration delays these changes somewhat, but they progress much more rapidly if the body is not refrigerated or if it is removed from the refrigerator. In order to avoid delay and embarrassment to the family and all concerned, as a direct result of the above mentioned postmortem changes and the problems thereby created, every effort will be made to avoid any unnecessary delay to embalm the body as soon as possible after death has occurred. This will require perfect coordination and cooperation between the pathologist, hospital personnel and staff, and the funeral director and/or embalmer in order to expedite the obtaining of necropsy permits, performance of the necropsy, release of the body, and performance of the embalming.

Hospital Cooperation

In order to expedite the obtaining of necropsy permits, performance of the necropsy, and the release of the body, the following is recommended:

(a) The hospital shall be responsible for informing all members of its staff—especially physicians, interns, residents, and nurses—of the importance of securing necropsy permits and arranging for the postmortem examination at the earliest possible time. In securing necropsy permits the members of the hospital staff shall make sure that the family understands the extent and nature, as well as the purpose of the examination. The funeral director, in turn, must take cognizance of the difficulties usually experienced by the attending physician and the hospital in locating the relatives and obtaining written permission for necropsies.

(b) Bodies shall be sent as soon as possible to the hospital morgue, where the body shall be maintained at a temperature of 40 degrees, so as to preserve the tissues for both the director and the pathologists. To prevent discoloration, the head and shoulders shall be elevated and the forearms shall be crossed over the torso and held by side gauze strips above the elbows, or elevated by means of blocks, or in some other fashion so as not to leave marks on the hands and wrists. Surgical dressing shall be left in situ. Bodies shall be covered loosely, but a special shroud is not necessary.

(c) The hospital shall notify the pathologist and ask the family to notify the funeral director as soon after death as possible, stating whether or not a necropsy is to be performed. Failure to do this causes embarrassment for the funeral director and the hospital authorities. It also disturbs the family of the deceased. As soon as the funeral director is contacted by the family of the deceased he shall telephone the hospital to ascertain whether a necropsy is to be performed, rather than go to the hospital unannounced to remove the body. Arrange-

*Approved by: State Medical Society of Wisconsin, Wisconsin Society of Pathologists, Wisconsin Funeral Directors Association, Wisconsin Hospital Association, and Wisconsin Conference of Catholic Hospitals, December 1952.

ments for embalming the body before or after the necropsy shall be made by consultation between the pathologist and the funeral director. The hospital shall notify the funeral director as soon as possible after death as to the approximate time when the body will be released.

(d) The hospital authorities shall maintain proper organization, facilities and equipment for securing necropsy permission and for performing necropsies, including:

1. Competent, orderly service in the necropsy room.
2. Suitable instruments and other equipment required by the pathologist.
3. A uniform, standard consent for necropsy, conformity to the laws of the State of Wisconsin, and in accord with the local situation.
4. Proper instructions to all employees concerned with the arrangements for necropsies, such as: office clerks, telephone operators, nurses and interns, so that they may intelligently and efficiently attend to the necessary details.
5. Refrigeration facilities are desirable equipment in all pathology departments. It is recommended that the body be kept at a temperature of 40 degrees, as outlined in paragraph (b) above.

(e) The hospital administrator shall designate the person in the hospital who is to assume responsibility in the absence of the pathologist and the administrator, so that the funeral director will at all times have a person of authority to consult regarding the necropsy and the securing of the body.

(f) The hospital administration shall see to it that no employee influences relatives of a deceased person in regard to the choice of a funeral director, nor that any member of the hospital staff, other than the pathologist, intern, or resident, is given the authority to discuss with relatives the nature of the necropsy to be performed.

(g) In accordance with the above, the official communications of the hospital are summarized as follows:

1. Obtain necropsy permit in duplicate from family.
2. Request family to notify funeral director of death, stating whether or not necropsy will be performed.
3. Notify pathologist and arrange schedule for necropsy.
4. Notify funeral director of schedule for completion of necropsy and release of body.
5. Transmit the duplicate copy of the necropsy permit with the body to the funeral director.

Pathologist Cooperation

The time of performing necropsies is to be as soon after death as possible. The pathologist shall report to the hospital the approximate time when the body is to be released. In cases where time for the release of the body is not important to the funeral director, the pathologist should be notified accordingly. In case shipment is to be made, or for other urgent reasons the funeral director is crowded for time in making necessary preparation, the pathologist should be notified so that he may give the funeral director the utmost cooperation in releasing the body.

For the convenience of the funeral director, and in consideration of the family, the necropsy should, if possible, be started within six hours following death. If a delay of more than six hours is anticipated between the death of the patient and the start of the necropsy, the funeral director shall be notified and it shall be his privilege either (1) to do the arterial embalming at the hospital morgue, or (2) to remove the body to his own establishment and do the arterial embalming there. The performance of the necropsy shall then be (1) at the hospital or (2) at the funeral home.

If the necropsy cannot be completed by 10 hours following death, the body shall be released to the funeral director without necropsy unless by mutual agreement between the funeral director and the pathologist.

Modification of the above two paragraphs if the body is at University Hospitals (Wisconsin General Hospital), Madison.

Because of many situations involving a necropsy performed at the University Hospitals (Wisconsin General Hospital), Madison, it is especially desirable to secure assurance of cooperation by seeing that the permit is received at the hospital as soon as possible following death. The authorities of University Hospitals (Wisconsin General Hospital) will make every effort to have the necropsy completed and the death certificate signed *within four hours after the permit is received by the hospital.*

While every effort will be made at University Hospitals to complete the necropsy within 10 hours following death, there may be special circumstances which make an extension of this time limit necessary. Such unusual situations will require the cooperation and tolerant understanding of the funeral director and the head of the pathology department.

Technic of Autopsy

(a) The "crutch" incision, common practice for many years, is to be used, starting at the anterior axillary folds, meeting the midline in the lower part of the chest. A midline incision from here on to the pubis complete the routine incision.

(b) An oblique incision in the abdominal wall should be avoided. If it is absolutely unavoidable the incision should be made from the internal side of the wall through the muscular wall.

(c) When removing material from orbits or mouth, neck, cheeks, or other soft areas, the tissues

should be handled with care as the slightest mutilation causes swelling during embalming.

(d) A portion of the aortic arch, the major arteries arising therefrom, and the common iliac arteries are to be left intact for the convenience of the embalmer. In cases where the organs of the neck are removed, the carotid arteries are to be left in situ.

(e) In any case where the brain is to be removed a transverse scalp incision located as far posterior as possible, and extending to both mastoid regions, is to be used. The skull is to be removed in such a manner as to facilitate its replacement without slipping or disfigurement.

(f) Every effort should be made not to distort the facial features, especially if the body must be turned on its face. When examining the thoracic cavity in no case is the sternum to be tied against the face in any way which might distort the features. Especially when working on the head great care should be used to preserve the features.

(g) Except when the extent of the necropsy is restricted by limitation of the consent, the organs shall be completely removed for examination and the body cavities cleaned before they are replaced. The gastrointestinal tract shall be opened.

(h) Care shall be taken not to sever the rectum too short or to cut the pelvic floor and allow leakage from the pelvis. If necessary the pelvic opening shall be closed by suture.

(i) The body is to be sponged free from fluid or blood. If hardening compound, cellucotton or some other filling is to be used in the body, the matter shall be left to the discretion of the embalmer. The body shall be left clean and dry.

Before closure of the cranial cavity the internal carotid and vertebral arteries shall be dissected and left long enough to be easily accessible for clamping. Hair, especially of females, shall be kept clean and rinsed with water after the scalp is closed.

Funeral Director and Embalmer Cooperation

(a) The funeral director is encouraged to point out to the relatives of the deceased the advantages of the necropsy, and in discussing the necropsy the funeral director will not influence families against giving permit for necropsies, reserving the duty to answer whatever inquiries they may have. Neither the hospital nor any member of its staff shall endeavor to influence relatives of a deceased person in regard to the choice of a funeral director.

(b) It is understood that the funeral director will refer relatives or other people to the family physician whenever any question regarding a necropsy is raised.

(c) When the necropsy is performed in the mortuary a duplicate consent for the necropsy is to be signed by the member of the family giving permission; one copy is to be retained by the pathologist and the other copy delivered to the funeral director.

(d) When arterial embalming is done before the necropsy, the embalmer should not disturb the organs of the thoracic or abdominal cavities, except in cases where it is necessary to reduce the gases. The embalmer may attempt to release pressure by any means known to him as long as the organs are not disturbed or damaged. Under no circumstances is a trocar to be used unless the technic is explained to the pathologist prior to proceeding, and permission to proceed is granted.

Violation Control

If any violation of the above code occurs an effort to adjust the difference shall first be made by the funeral director, the pathologist, and the hospital concerned. If no satisfaction is obtained by such effort the violation may be referred to a group of persons to be known as the Coordinating Committee, to be selected annually. This committee shall consist of one pathologist, selected by the Wisconsin Society of Pathologists, one physician, selected by the State Medical Society; one hospital superintendent, appointed by the Wisconsin Hospital Association (who shall be chairman of the committee); one representative of the Wisconsin Conference of Catholic Hospitals; one funeral director and one embalmer, both selected by the Wisconsin Funeral Directors Association. Whenever a member of this committee is involved in a dispute, an alternate shall be selected from his group to take his place temporarily on the committee. While the committee has no arbitrary powers, it is expected that those involved shall abide by its decisions and recommendations.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Chicago, May 7, 8, and 9, 1953, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than February 15, 1953. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

Malpractice and the Physician*

By LOUIS J. REGAN, M. D., LL. B.

THE incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. If this alarming situation were evidence that the medical profession was becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all malpractice suits filed are without merit; more than half of them involve physicians who are above the median of their respective groups in skill, experience, and professional standing. The search for a solution to this problem demands an understanding of what actually constitutes malpractice, an analysis of the causes of malpractice claims, and a universal knowledge among physicians as to the positive steps which may be taken to decrease both the relatively few justified claims and the preponderantly greater number of unjustified claims.

Any Physician May Be Sued for Malpractice

The bringing of a malpractice action does not even suggest that the claim has merit; for any patient may bring such an action against any physician who has attended him professionally. Nevertheless, the practitioner who is the target of the accusation is damaged by the mere filing of the action. Accordingly, it is necessary that every physician understand what constitutes malpractice under the law.

What Constitutes Malpractice Under the Law?

The law requires that a physician who undertakes to diagnose or to treat a patient must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist, he must meet the standards of practice of the specialist in the designated field of practice. These legal interpretations of his duty are not changed if the professional services are rendered gratuitously. It follows, then, that no malpractice charge is justifiable unless the physician's service to the patient does not meet the requirements of good medical practice; unless in the diagnosis or treatment of his patient, the physician omits to do something he should do or does something he should not do in terms of accepted standards of practice. The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases.

This definition of standards needs further clarification; for medicine is not an exact science, and not all patients who are given medical treatment get well. Many are left with some disability or deformity. There are few conditions in which there is available a sole, specific, universally utilized remedy or procedure. There is frequently a great latitude for honest difference of opinion, and often the attending physician must exercise his best judgment in deciding which of the several methods to adopt. In certain circumstances, the physician's acts or omissions may be so unseemly and shocking as to be generally recognized as reprehensible and supportive of legal liability. On the other hand, complications or untoward and unexpected results are not uncommon, and the mere fact that a patient is not cured or does not progress favorably does not suggest culpable ignorance or negligence on the part of the medical attendant.

Under Law, What Skill and Care Has the Patient the Right to Expect?

In the absence of evidence to the contrary, the law presumes that a physician has exercised the ordinary skill and care required of him in treating his patient. He is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality. He may make a mistake in diagnosis or be guilty of an error of judgment; he may use medicines or methods of treatment different from those which some of his colleagues would have used; he may obtain a bad result instead of a satisfactory one; but no one of these things is sufficient to fasten upon him the charge of malpractice. Actionable malpractice consists in doing something that should not be done or in omitting to do something that should be done.

Malpractice Suits Lessen Public's Confidence in Medical Profession

It is of primary importance, of course, that every physician familiarize himself with his legal interpretation of what does and what does not constitute malpractice. But that is only the first part of the control of the malpractice contagion; for experience has taught us that the most meticulous attention to the dictates of good medical practice is not sufficient to ward off unjust claims and that no physician, regardless of his excellence, is immune. The misunderstanding, indeed the ill will, which has been engendered by the great number of unjust malpractice suits has tended to break down the public's confidence in the medical profession. This situation has important and far-reaching implications for both the public and the medical profession; for the public interest is adversely affected when the physician in

* Reprinted, with permission, from the Journal of the American Medical Association, September 2, 1951.

caring for his patient is forced to give thought, time, and energy to safeguarding himself against the possibility of an unjust malpractice claim. The public should be informed of the facts of this problem, for in the long run, it is the public—in the persons of individual patients—whose well being is being jeopardized. There is no relationship outside the family which is so personal and intimate as that of physician and patient, no relationship in which the character, integrity, and conscience of one party are so important to the well being of the other. The overwhelming majority of physicians faithfully and unselfishly meet the demands and obligations of their calling; and the majority of patients do not unjustly file malpractice suits. The acts of the ignorant, the greedy, the callous few—among either patients or physicians—must not be permitted to destroy the merited esteem in which the profession as a whole is held.

How Much Shall the Physician Tell His Patient?

As a basic step in improving the situation, the physician must realize that at all times he is obligated to act with the utmost good faith toward his patient. Thus, if he knows that he can not accomplish a cure or that the treatment adopted will probably be of no benefit, he is duty bound to advise his patient of these facts. It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient. Such completely open handling of a case would do much to improve the physician-patient relationship and to remove the possibility of unjust malpractice actions. However, there are other unavoidable and even psychological factors in the practice of medicine which must also be considered carefully in this respect.

Factors That Promote Malpractice Suits

If physicians were always able to obtain perfect results there would be, of course, no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Whether or not the uncured patient brings an action is often determined by his feeling toward the physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not so likely to sue for malpractice—even when bad results ensue. Malpractice suits more often arise if the patient is resentful of some fancied or actual affront, if he believes that he has not been sufficiently closely attended, or—above all—if some third person raises a doubt in his mind as to the propriety of the treatment. In regard to this last point, it would be sheer folly to assume that the "third person" is always—or even most often—a layman who is uninformed about the facts of the case. Regrettably, many of these people are physicians who are also uninformed about the details and facts but who precipitate unjustifiable suits by criticising directly or by implication the work of physicians who have cared for particular cases.

Another potential danger to the physician-patient relationship arises from the physician's lack of attention to certain elements of patient psychology as factors in malpractice causation. Although the patient is sick or injured when he comes to his physician, he nevertheless visualizes himself as he was prior to becoming sick—with his body structures intact. Thus, unless the physician understands this viewpoint and prepares the patient properly, the patient with a fracture, for example, is likely to compare the final result with the part prior to injury, not with the injured member as presented to the physician. As another example of patient psychology, the average patient is not disposed to understand an error in diagnosis or the failure to make an early diagnosis. Or again, the unwarned patient is not happy with the surface tissue changes which are some times associated with deep x-ray therapy.

An analysis of malpractice claims reveals the significant fact that they arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates a suit against his physician. It is obvious, then, that from the very first contact—indeed, especially with the very first contact—the physician should do everything within his power to develop an honest, frank, and psychologically sound relationship with his patient.

How Physicians May Safeguard Themselves Against Malpractice Suits

The foregoing discussion has analyzed what malpractice is and what can be done in the physician's conduct to avoid real malpractice or to forestall the filing of an unjust claim. But it would be completely unrealistic to assume that any course of conduct on the part of the physician would prevent his being unjustly sued for malpractice. Good medical practice in itself is not enough; the physician must be able to defend his actions by proof of what he has done. He must not only know his legal duty to his patient, but he must fulfill it. He must know and take advantage of every measure to protect himself against the unjustified claim of malpractice. Under present circumstances, it is absolutely foolhardy for any physician to be ignorant of or careless of malpractice prophylaxis. He must take positive actions carefully based upon his legal responsibilities and liabilities.

To begin with, a physician is not legally obligated to undertake the care of any patient. But from the time he assumes the responsibility until he is discharged or withdraws from the case, he must give—or be sure that there is given—the care and treatment required by the condition of the patient. Before a physician may, without legal liability, with-

draw from a case he must give reasonable notice of his intention and allow the patient reasonable opportunity to fill his place.

By notice or special contract, the physician may limit the service he is to render. He may agree to treat the patient only at a certain place, or for a limited time, or for certain conditions. On the other hand, he may increase his obligation by expressly agreeing or warranting that he will effect a particular result; in this circumstance, he will be liable on his contract or warranty if he fails to fulfill the agreement. A physician is not an insurer of results unless he makes himself one by his special promise.

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse, to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be construed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

Expert Testimony and Res Ipsa Loquitur

Generally, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur*[1] in a case gives rise to an inference of negligence on the part of the defendant, and relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalities, (4) roentgen radiation injuries, generally limited to cases wherein the roentgen ray is being used diagnostically, (5) infection through the use of an unsterilized needle or instrument, and (6) injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

[1] *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

A Good Case Record is a Valuable Safeguard

The importance of good medical case records, as a factor in malpractice prophylaxis can not be overestimated. A good medical case record should contain a history[2] of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as the basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will reflect (by means of progress notes) a sequential history of the case, its course, complications, and sequelae and, thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case are also a part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course.[3]

Unwarranted Professional Criticisms Promote Malpractice Suits

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticise destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient.

Other Preventive Precautions

The importance of tact can hardly be overemphasized. It should be manifest especially in the handling of the patient and the patient's family; in the avoidance of fee disputes and unwise efforts and methods in the collection of fees (considering the provisions of the statute of limitations); in the avoidance of overoptimistic prognoses and especially of any promise constituting a guarantee of a par-

[2] It is important to indicate the source of the medical history (from the patient, member of family, etc.).

[3] There is a legal presumption that a letter mailed has been received by the addressee; but there is no presumption that a letter has been mailed.

ticular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting (or which might be construed as) an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; and in the securing of legal advice before making any statement in regard to a malpractice claim or suit.

Liability for Acts of Others

In addition to being responsible for his own acts and omissions, a physician encounters, in his everyday practice, instances in which he may also be responsible for the negligent acts and omissions of others. Thus, he is responsible for the acts of his assistants and employees, for their negligence occurring during the course of their employment. Where doctors practice as partners, each partner is liable not only for his own acts and those of his partner, but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligent acts of the other which he has observed or which in the exercise of ordinary diligence he should have observed.

The attending physician is generally not liable for the negligence of an interne, a nurse, or other hospital employee. He is, however, responsible for the acts of the hospital personnel in so far as they are carried out under his immediate supervision and control. Thus, the operating surgeon and not the hospital is held liable for any negligence of operating room attendants during the performance of surgery.

Consent for Operations, Treatment and Autopsies

Consent for operation must always be secured. Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, the physician should invariably require a witnessed consent in writing. If the patient is a minor (that is, a person under the age of twenty-one) consent is to be obtained from parent or guardian.[4] If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required.

When an operation is made compulsory by law (such as vaccination or sterilization[5]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform without consent such operation as good surgical practice demands.[6]

If sterility is likely to result from the surgery which is contemplated, explanation of that probability should be made and a signed authorization obtained from both spouses. It should be borne in mind that it is hazardous to sterilize any person except upon a positive medical indication. Further, there should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken.

The individual physician must secure consent to perform a postmortem examination. This, too, should be in writing[7] and sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

The trend of the cases in recent years indicates that it is extremely unwise to pursue a course of treatment in itself hazardous or capable of producing harmful effect without securing a written statement from the patient, or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the special treatment.

Failure to Use Recognized Diagnostic Aids

There are a large number of malpractice actions in the law reports which may be classified under the general heading of "Insufficient Treatment Cases." In every field of medical practice there are cases illustrating "insufficient care": the failure to make a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up; failure to make a complete diagnosis or overlooking a reasonably determinable condition; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); the failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts, etc., etc.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. Whenever a fracture is present which was not diagnosed and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standard of good practice.[8] Whenever a bad re-

[4] Statutory exception: In California a female of the age of 18 or more who is or has been married is an adult for the purpose of this consent.

[5] Under Eugenic Sterilization Statutes.

[6] 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.

[7] In California, and several other states, it is criminally illegal for any person to perform an autopsy without having first obtained the written authorization of the coroner or other authorized public officer or of the person who has the right of disposition of the body.

[8] "The failure to make use of x-ray as an aid to diagnosis in cases of fracture amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing in the community and the court, in absence of expert testimony, may take judicial notice of such fact." Agnew v. City of Los Angeles (Cal.), 218 Pac. (2d) 66.

sult, deformity or limitation of motion occurs, the defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Whenever a patient refuses to have an x-ray made, the physician should fortify himself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice action may be brought.

The statute of limitations provides the period of time after which specified actions may not be brought. The time provided varies greatly in the several states. A physician should wisely inform himself of the situation in his own state.

Obligations to Patients

To summarize, the physician who would understand his legal obligations, responsibilities, and duties to his patient, must constantly bear in mind the following fundamental obligations:

1. The physician must possess the degree of skill commonly possessed by other reputable practitioners in the same field of practice.

2. He must exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

3. He must keep abreast of progress and follow good practice, common practice, in diagnosis and treatment; he must not experiment.

4. He must not neglect or abandon his patient; he must proceed diligently, without unnecessary delay.

5. He must give his patient sufficient attention and must utilize the indicated diagnostic aids.

6. He must find or anticipate any condition reasonably determinable or reasonably likely to develop.

7. He must obtain legal consent to operate and to perform an autopsy.

8. He must give proper instructions (that is, instructions consistent with the standard of practice) for the care of the patient in his absence, and for the protection of those coming in contact with the patient.

9. He must fulfil the terms of a special contract if he makes one.

The foregoing directions for reducing and avoiding the instigation of malpractice suits will not, of course, guarantee that a physician will not be sued unjustly; for already malpractice may be regarded as a contagious disease of the social body. There are several major reasons for this condition, but two are paramount: (1) the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious"; and (2) such suits are difficult to defend, and the knowledge of how best to conduct such a defense is not sufficiently widespread. The inter-relationship of these two points will be obvious; for each successful defense of an unjust suit will serve as a discouragement to the filing of others. But the second of these causes of high malpractice incidence—the difficulty of conducting a defense—is dangerously enlarged by many physicians themselves. Large numbers of medical men are naive enough to believe that their patients would never file such suits and that no precautions need be taken; and yet such precautions are the only assurance of the best possible defense in the event of a suit. The most vulnerable physicians are those who know that they are maintaining at least an average standard of practice and who are therefore (and blindly) assuming that they will not be sued. This discussion is concerned with *unjust* claims; no doctor who is actually guilty of malpractice should be allowed to go free of penalty. Meritorious claims should be settled out of court—preferably before a suit has been filed.

Prompt Attention Should Be Given to Claims

Another too frequent hindrance to an adequate defense is delay in the investigation of claims; such delay is highly disadvantageous to the preparation of a defense. As a final word of warning that the physician may need every available precaution, one must consider the conditions under which most cases are heard. They are tried before juries made up of lay persons, and it is a truism that no one can say what a jury will do. This is particularly true of malpractice cases, for certainly lay jurors can not be expected to understand complex medical facts. How does a jury arrive at a decision when two expert witnesses testify that the defendant's conduct of the case did not meet the required standard, and two others declare that what the defendant did was consistent with the usual and ordinary practice in the community?

To physicians who have had little or no experience with the law and to lawyers who have little or no medical knowledge, the problem of adequately defending the unjust malpractice case seems insurmountable. And it is true that far too many such cases have been lost simply through poor defense. This is an aspect of the problem which needs a great deal more attention, particularly in areas which have become virtual "hot beds" of non-meritorious malpractice claims. At all times and to all physicians, there should be available expert advice on problems relating to the physician-patient relationship.[9] Whenever a threat is made against a physician, a carefully prepared procedure should be put into effect. Unjustified claims should be contested as thoroughly as possible. In such cases, it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course simply serves as an encouragement to others whose claims are not justified. This shortsighted view is largely responsible for the rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

[9] Regan, L. J.: Doctor and Patient and the Law, St. Louis, The C. V. Mosby Company, 1949, chap. 20.

Be Slow to Compromise

It is a great temptation to a doctor to rid himself of a nuisance claim by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often true, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim.

A List of "Commandments" in Malpractice Prevention

In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments":

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician should keep "ideal" medical records in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from overoptimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

11. The physician should have some knowledge of the statute of limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

Conclusions

There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to correct it.

The public should be informed as to (1) what constitutes malpractice, (2) how really few cases of actual malpractice occur, and (3) the major degree of responsibility which the individual has in the maintenance of his own health.

Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

Addenda

I. Consent to Operation

Place _____

Date _____

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me_____ _____ _____ and to do any other procedure that (their) (his) judgment may dictate during the above operation.

2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____ I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.

3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

A.M. Signed _____

Hour _____P.M. Witness _____

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.[1]

Date _____ Signed _____

A.M. Witness _____

Hour _____

P.M.

1. Cross out paragraphs not applicable to particular case.

II. Consent to Operation upon Minor

Place _____

Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ____, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anesthetic or anesthetics in this case.[2]

2. A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

A.M. Signed _____( )

Hour _____P.M. _____

Witness _____

III. Consent to Observers and/or Photographs and/or Televising

In the interests of science and the furtherance of medicine, I, the undersigned, do hereby consent to and authorize _____ Hospital, and the Operating or Treating Surgeon and such doctors as may be assisting him, to examine and operate or treat me in the presence of other than the usual surgical staff.

I further authorize and consent to the taking of photographs and such subsequent use thereof as may be deemed advisable by said hospital and/or doctor, or doctors.

I further authorize and consent to the televising of any operative or other procedure performed or carried out upon me.

Dated _____ Signed _____

Witness _____ Witness _____

IV. Patient Fails to Carry Out Advice

Note. When a patient neglects or fails to carry out advice, it is desirable to have the facts established in writing. It may be wiser to withdraw from the case (See VII). This is a matter for the judgment of the physician in the particular case.

SAMPLES[3]

3. Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Place _____

Date _____

A.

Name of Patient

Address

Dear Mr. _____:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

B.

Dear Mrs. _____:

Upon the history you gave me and my findings on examination, both of this date, I am not able, as I told you at the time of your visit, to rule out pregnancy as the cause of the vaginal bleeding of which you complain.

You have told me that you will not submit to a pregnancy test. I again now advise you of its desirability. I hope you will come in tomorrow morning prepared, as I instructed you, to have the test made. If you continue to refuse to submit to this test, it will be necessary to have a consultant see you tomorrow, if I am to continue to advise you.

Yours very truly,

C.

Dear Mrs. _____:

When, in response to your call today, I saw your husband at your home, I told you my opinion was that he is very seriously ill with pneumonia, and that he should be immediately hospitalized. You refused to permit me to have him removed to the hospital. I told you that I am willing to do the best I can for him under the circumstances, but that he could be better cared for and he would be safer, with less likelihood of complication, in the hospital.

Your husband's condition is such that the matter cannot be discussed with him, so I hope that you will now after giving the matter more thought, authorize his removal to the hospital.

Yours very truly,

D.
Dear Mrs. _____:

You brought your seven-year old boy in today for me to see. He has a deep, penetrating wound on the sole of his foot, apparently resulting from his stepping on a nail. You thought that it had been received in a neighboring stable.

I advised you that the boy should immediately be given an injection of tetanus antitoxin. You refused to permit me to administer this to him, stating that you had heard of two children who had severe reactions following such prophylactic treatment.

I told you that I would make a preliminary test which would warn us of the likelihood of severe reaction, but that I could not guarantee that result or any result. You reiterated your refusal.

I cannot give the boy this treatment, or any treatment, without your consent. I urgently recommend that you permit me, or some other physician of your choice, to administer a preventive dose of tetanus antitoxin to your boy without further delay.

Yours very truly,

V. Patient Fails to Keep Appointment

SAMPLES[4]

4. When a patient fails to keep an appointment, or discontinues treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

My records indicate that you failed to keep your appointment of _____ (date), and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention is, in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

Yours very truly,

B.
Dear Mrs. _____:

You have not returned, as arranged, since, at your request, I examined you on last Friday.

The history you gave of "spotting" between periods over the last several months, and my findings on examination, which I related to you, are of such significance that, as I endeavored to impress upon you when I made an appointment for you to return with your husband, I must urge upon you the advisability of having immediate medical attention.

If you do not wish to return to me, you should consult another physician at once.

Yours very truly,

C.
Dear Mrs. _____:

You failed, again, today to appear in accordance with your appointment at the Radiologist's office so that a check-up x-ray could be made of your fractured wrist.

I have previously urged upon you the necessity of having your cooperation to improve the likelihood of a favorable result.

You should not be heard to complain of the end result, if it is not satisfactory, when you refuse or neglect to follow the advice of your physician.

I now request that you appear at my office at ten o'clock tomorrow morning. I am arranging to have x-rays made at that time and to have a specialist in orthopedic surgery see your arm.

Yours very truly,

VI. Patient Discharges Physician From Case[5]

5. If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Dear Mr. and Mrs._____

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

VII. Physician Withdraws From Case

Note. A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. If the fact, whether a physician did withdraw from professional attendance upon a patient, became an issue in the case the burden of proof falls upon the physician. For this reason, it is desirable that written evidence be available.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

SAMPLES[6]

6. Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

You have repeatedly failed to follow my advice and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly,

B.
Dear Mr. _____.

You consulted me this afternoon in connection with an injury to your foot and ankle. At that time, upon your refusal to have x-rays made of the injured area, I advised you that I could not undertake to render professional service to you.

So that there may be no misunderstanding, I am confirming these facts in writing.

Yours very truly,

C.
Dear Mrs. _____:

As I told you this morning, I cannot longer continue to be professionally responsible for the care of your little boy. This decision is necessitated by the fact that you have repeatedly refused to permit me to make the detailed and thorough study of his condition which I regard as indicated and vital.

Please secure other medical attention at once. In the meantime, and for a reasonable time, I shall remain available, at your request, to render any routine or emergency service that may be required.

I shall, of course, be glad to offer to Tommy's new physician the knowledge of his case which I have been permitted to acquire.

Yours very truly,

D.
Dear Mrs. _____:

You failed to keep your appointment this week.

At the time you received your injection last week a portion of the needle broke off in your tissues. You were at once advised of this accident. As I told you, after preliminary search, I was unable to recover the broken piece without anesthesia and incision, and recommended that localization studies be made prior to undertaking definitive search.

I again recommend that procedure and will make arrangements at your request and responsibility.

Yours very truly,

Civilian Medical Care For Army, Navy and Air Force Personnel and Their Dependents

THE rapid expansion of the Armed Forces has created a situation in which it is advisable for the civilian physician to understand the rules and regulations which govern the furnishing of medical care to service personnel and their dependents. The following article presents current regulations relating to the Army, Navy, and Air Force.

It is noteworthy that there is no provision in existing laws or regulations whereby dependents of military personnel in the Army, Navy, or Air Force may obtain civilian medical care at the expense of these branches of the service.

ARMY *

One of the most important and necessary services furnished the American soldier is adequate and timely medical care and treatment, including hospitalization. This service is provided for Army personnel in the United States generally by dispensaries, infirmaries, and hospitals located at the many Army installations throughout the country. There are many locations, however, where Army or other United States federal medical treatment facilities are not available when medical service is required by Army personnel. In cases of this nature, the services of civilian physicians, clinics, and hospitals are necessary. With the expansion of the Army and the deployment of Army personnel to practically all points in the United States either on a duty, travel, or leave status, the continued cooperation of civilian physicians and agencies is of utmost importance in providing adequate medical service to the U. S. soldier in time of need.

Certain criteria and procedures have been established in connection with the furnishing of medical service to Army personnel by civilians in accord with the current laws and regulations. These criteria define the conditions under which individuals of the Army may be authorized civilian medical care at the expense of the Army. These procedures include methods for reporting and receiving payment for treatment or hospitalization of Army personnel by civilian medical agencies.

Civilian medical care (other than elective) at the expense of the Army is authorized for officers, warrant officers, enlisted personnel and cadets of the United States Military Academy when these personnel are on a duty status or when they are absent from their place of duty on any authorized leave or pass. Payment for civilian medical expenses incurred by these personnel who are absent without leave is not authorized. Any obligations resulting from civilian medical care to Army personnel who are absent without leave are the sole responsibility of the individual concerned. Also authorized necessary civilian medical care at the expense of the Army are applicants for enlistment or reenlistment and inductees while they are being processed for enlistment or induction into the Army, prisoners, and prisoners of war.

Normally, civilian medical care for Army personnel is authorized only when there are no other federal medical treatment facilities available. First aid or emergency treatment is authorized at any time, notwithstanding the proximity of Army or other federal medical treatment facilities. In this connection, emergency medical care may be defined as that required to save life, limb, or prevent great suffering. Surgical operations should not be performed without prior approval of military authorities, unless indicated as an emergency procedure. Elective medical treatment in civilian medical treatment facilities or by civilian physicians will not be authorized as Army funds cannot be used for payment of these services.

Medical care of dependents of military personnel from civilian sources, at Army expense, is *not* authorized. Dependents of military personnel may obtain available medical care at Department of Defense medical facilities only. Any obligations resulting from civilian medical care to dependents of military personnel are the responsibility of the dependents concerned or their sponsors.

As a general rule, local military commanders will furnish the civilian medical agency with prior written authority for ordinary medical care to Army personnel under his jurisdiction. In such cases, prior arrangements with the civilian medical agency will be made by the individual or by a proper military authority. For emergency cases treated without prior written authorization, the surgeon of the nearest military command should immediately be notified by the civilian medical agency, giving the individual's name, organization, nature of illness or injury and statement of the practicability of transfer of the patient to an Army or other governmental hospital. The civilian agency or physician then will be advised without delay by the appropriate military authorities as to procedures to be followed.

Bills for authorized medical care and treatment of Army personnel should be submitted to the commanding officer of the organization to which the patient belongs, or to the military authority who provided the authorization for the medical service. If the location of these individuals is not readily known, or if such military commanders authorizing treatment have moved to another station, the bill

* From Fact Sheet, Department of the Army, Office of the Surgeon General, Washington 25, D. C., 15 November 1951.

should be sent to the military authorities at the appropriate Army Area. For services rendered in Wisconsin, submit bills to The Surgeon, Fifth Army, 1660 East Hyde Park Boulevard, Chicago 15, Illinois.

The bill should show the full name, rank, and service number of the patient, place, and inclusive dates of treatment, diagnosis, and charges, all itemized separately. The duty status of the patient at the time of illness or injury also should be shown, such as duty, leave, or pass. Payment will be expedited if the following certificate is typed on the bill and signed:

"I certify that the above charges are correct and just; that payment therefor has not been received; that the services were necessary in the care and treatment of the person named above; that the services were rendered as stated; and that the charges do not exceed those customarily charged in this vicinity."

--- ---
(Signature of Payee) (Title or Capacity)

Answers to specific questions or further information concerning this matter may be requested of the military surgeon at the aforementioned address or from the Surgeon General, Department of the Army, Washington 25, D. C. Any difficulties that are experienced should be called to the attention of Army authorities in order that this program may function smoothly and render the American soldier the prompt and adequate care and treatment to which he is entitled.

NAVY *

The following regulations apply only to Navy or Marine Corps personnel. At this time there is no provision for the civilian care of dependents of such personnel at government expense.

20–1. General Summary

(1) Personnel on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment at Government expense by any Federal activity, other than naval, having a medical service (Army, Public Health Service, and Veterans' Administration) under the following conditions:

(*a*) When on duty at a place where appropriate facilities or personnel of the Medical Department of the Navy are not available, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to the Federal activity concerned (art. 20–4).

(*b*) When on authorized liberty or leave in an emergency which does not permit return to the duty station or application to another naval activity having facilities for the necessary treatment.

(2) Personnel on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment and hospitalization at Government expense in other than Federal hospitals under the following conditions:

(*a*) When on duty at a place where there is no Federal medical or dental facility, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to a civilian physician, dentist, or hospital (art. 20–4).

(*b*) When on authorized liberty or leave they become ill or are injured and the emergency does not permit application to a Federal medical or dental facility. Under such circumstances approval of their commanding officer should be obtained or, if this is impracticable, prompt report should be made to the commanding officer in order to permit investigation and suitable arrangements for transfer of the patient to a Federal institution or other appropriate action.

(3) The accounts of officer personnel receiving treatment in Federal hospitals other than Navy or in civilian hospitals at Navy Department expense will be checked for subsistence the same as when they are patients in naval hospitals (par. 5146.3, 1945 Manual).

20–2. Limitation on Emergency Dental Treatment

The expense of emergency dental treatment by other than a naval dental officer shall be allowed under the conditions specified in article 20–1 only to relieve pain or abort infection and upon the approval of a naval medical officer, if one is available. Emergency treatment shall not include the furnishing of prosthetic appliances including crowns or inlays, or the use of gold or other precious metals for fillings. (See arts. 20–14 and 20–15.)

20–3. Prompt Report Necessary in All Cases

Expenses incurred for medicine, medical or dental attendance, or hospitalization from sources other than the Navy may not be allowed in any case specified in article 20–1 unless the sickness or injury has been promptly reported to the Bureau by the medical, dental, or other responsible naval officer having cognizance of the case, or by the individual concerned when on detached duty or on authorized liberty or leave where a superior officer is not present. (Refer to arts. 20–7 and 20–8.)

20–4. Personnel in General

Personnel of the Navy and Marine Corps attached to and serving at a place where there are no Federal medical or dental facilities may be sent to other facilities upon the order of the commanding officer or the senior officer present. When on detached duty where a superior officer is not present, and naval medical or dental personnel or facilities are not available, the personnel should, if practicable, apply first to medical or dental facilities of other Federal departments or agencies. In the absence of Federal facilities, they may apply to a civilian physician, dentist, or hospital for necessary emergency treatment.

* Excerpted from Manual of the Medical Department, U. S. Navy, Chapter 20; effective 13 August 1951.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

20–5. Personnel on Liberty or Leave

(1) Personnel who require emergency medical or dental treatment while on authorized liberty or leave shall apply, if practicable, to the nearest naval activity in the vicinity; if emergency treatment is not available application should then be made to any other Federal agency having medical services. When Federal facilities are not available, the individual concerned or someone on his behalf should, if practicable, contact his commanding officer by telephone or telegraph reporting the emergency condition and requesting permission to obtain civilian medical or dental aid. Commanding officers may authorize such necessary emergency treatment as the circumstances seem to warrant, and should give appropriate instructions regarding submission of reports and bills and disposition of the patient upon completion of treatment (arts. 20–7 and 20–8).

(2) When the urgency of the situation does not permit obtaining treatment from Federal facilities or authority to obtain treatment from other sources, necessary emergency treatment may be obtained from civilian sources by or on behalf of the individual concerned, and reasonable expenses therefor may be allowed as a charge against the Navy; provided that, within a reasonable time, report is made to his commanding officer so as to permit investigation and suitable arrangements for transfer to a Federal institution or other appropriate action.

(3) Expenses for the employment of consultants or specialists shall not be allowed except when authorized in advance by the Bureau or, in extraordinary cases, when subsequently approved by the Bureau upon receipt of prompt report and satisfactory explanation as to the necessity and urgency of their employment.

(4) Civilian medical or dental treatment of personnel absent without leave is not authorized unless and until the individual comes under military or naval control.

(5) The expense of elective medical or dental treatment may be allowed under no circumstances. Civilian dental treatment, other than emergency measures to relieve pain or abort infection, is not authorized (arts. 20–2, 20–13, 20–14, and 20–15).

20–6. Retired Personnel

Retired inactive personnel and inactive members of the Fleet Naval Reserve and Fleet Marine Corps Reserve are not entitled to medical and hospital treatment at Federal expense in other than naval hospitals, except under provisions of paragraphs 16B2, 16B9, 16B34, and 16B35, 1945 Manual.

20–7. Reports Required in Cases of Emergency Medical or Dental Treatment or Hospitalization

(1) Report on NAVMED–U shall be promptly forwarded in duplicate to the Bureau in each case of any sickness or injury of personnel on active duty in the Navy or Marine Corps in which treatment is received from other than the medical or dental departments of the Navy. It is required in all cases in which medical, dental, or hospital treatment is furnished by civilian physicians or dentists, civil hospitals, or Government hospitals other than naval to Navy or Marine Corps personnel under circumstances that eventually may be used as the basis of a claim against the Navy Department. This report should be prepared by a naval medical or dental officer when practicable, and in the absence of such officers, by the senior officer present or by the individual concerned as soon as he is able.

(2) Commanding officers are responsible for bringing the foregoing to the attention of all personnel of the command who go on liberty or leave or who perform detached duty.

(3) When printed NAVMED–U Forms are not available, a typewritten report shall be made in duplicate giving the following information:

Name and rank or rating; date and place of birth; station to which attached; diagnosis; prognosis; status (leave, etc.). If on liberty or leave state exact period for which granted and the hours and dates of departure and return to station; circumstances; disposition; give dates on or between which services were rendered. By whom were the services rendered? When authority is given in writing a certified copy of same shall be attached. When authority is given verbally a certificate of the officer granting same shall be attached and shall show when and under what circumstances the services were authorized. Were the services of a naval medical or dental officer, or a naval hospital or dispensary available? In the case of an officer, the date of his orders and the name of the activity and disbursing officer carrying his accounts shall be stated, in order that his accounts may be checked by the Bureau in accordance with paragraph 5146.3, 1945 Manual.

(4) A supply of NAVMED–U's may be obtained from the nearest district publications and printing office.

20–8. Preparation of Claims

(1) All claims for expenses incurred for medicines, medical or dental attendance, or hospitalization not obtained from the Medical Department of the Navy shall be forwarded to the Bureau for adjudication. If approved by the Bureau, such claims will be forwarded to the Navy Regional Accounts Office, Washington 25, D. C. for payment. Payment of such claims may be made direct to the physician, dentist, or hospital, etc., rendering services or furnishing supplies, or reimbursement made to the individual receiving services or supplies if the cost thereof has been defrayed by him. (Refer to art. 20–8 (4).)

(2) Bills for treatment in Government hospitals other than Navy should be submitted to the Bureau for payment in accordance with existing regulations of the department or agency concerned.

(3) Unpaid bills for civilian medical or dental treatment or hospitalization of naval personnel should be forwarded to the Bureau for action. They

should be prepared in duplicate, itemized to show the dates on or between which services were rendered or supplies furnished, and the nature of and charge for each item. The bills should be certified as "Correct and just; payment not received" with the autographic signature of the payee or, in the case of a company or firm, of a responsible official thereof, whose title or connection therewith should be indicated. Receipt of the services or supplies should be acknowledged on the face of the bill, or by separate certificate, by the person receiving treatment, or by an officer having cognizance of the case. The dates, charges, etc., should be carefully checked and verified when practicable. Separate certified bills should be submitted for services of special nurses, anesthetists, or other persons on a fee basis, unless the bill including such services is accompanied by receipts to show that the expenses have been defrayed by the physician, dentist or hospital submitting the bill, or by a statement to the effect that the individual is a full-time employee of the payee.

(4) In cases where the expenses have been defrayed and receipted bills are submitted, claim for reimbursement may be made by the person defraying the expenses by placing the certificate "Correct and just; payment not received" on the face of each receipted bill and signing same, or in cases of naval personnel, by completing and signing the certificate on the reverse of the NAVMED–U. In either of these cases the complete address to which the check is to be mailed should be indicated.

20–9. Services of Specialists

(1) When the services of a naval medical or dental officer are available and when, in his opinion, he is not sufficiently experienced to properly treat the condition, or lacks the proper equipment or facilities for the required treatment, the Bureau should be contacted and authority obtained for the employment of a civilian physician, dentist, or other acceptable specialist, or procurement of special tests, examinations and hospitalization. In exceptional cases only, where the emergency will not permit sufficient delay to obtain advance authority, the Bureau will, upon receipt of prompt report and reasonable justification as to the necessity and urgency for the action taken, give subsequent approval therefor.

(2) The provisions of article 20–9 (1) shall apply also to the employment of specialists or procurement of special services in connection with treatment of the personnel of other Government departments or agencies who are patients in naval hospitals.

20–10. Procedure in Making Requests

(1) Advance requests for the employment of a specialist or for services of a special nature may be made by letter or dispatch to the Bureau, according to the urgency of the case, stating the nature of the illness, the condition of the patient, and the necessity for the special treatment or services, together with an itemized estimate of the cost thereof.

20–11. Refraction of Eyes and Procurement of Eyeglasses

(1) Naval personnel who need new spectacles or replacement for damage or loss in line of duty and are unable to avail themselves of Navy or other Federal facilities should, if suitable prescription is not available in their record, request the Bureau's authority for eye refraction from civilian sources, via official channels, stating the need and estimated cost. If request for refraction is approved, the prescription from the refractionist with proper facial measurements and the Bureau's authorization should be sent to the nearest Navy optical dispensing unit within the continental United States or to the nearest Navy optical service unit outside the continental limits of the United States. The optical dispensing or service unit shall fabricate or cause to be fabricated the glasses as ordered by the refractionist and shall forward them for proper checking and fitting by the civilian physician or specialist concerned.

(2) Whenever practicable in the absence of Navy facilities, eye refraction should be obtained from facilities of the Army, Public Health Service or Veterans' Administration, with the above procedure being followed in filling the prescription. The prior authority of the Bureau is not required to obtain refraction in one of these Federal facilities; however, authorization should be issued therefor by the individual's commanding officer or the senior officer present.

(3) All naval personnel attached to Naval Shore Establishments and working in trades or areas determined to be eye-hazardous shall be furnished satisfactory eye protection. When corrective-protective glasses are required by these naval personnel, all such glasses shall be furnished by the Medical Department activity of the establishment as a proper charge to the appropriation "Medical Department, Navy." In some instances prescription for such glasses may be in the individual's record; otherwise necessary refraction should be obtained from naval sources, or, if impracticable, from other sources in accordance with instructions in the preceding articles (20–11 (1) and 20–11 (2)). The furnishing of protective goggles of various types with Plano heat-strengthened or hardened safety lenses to naval personnel, who do not require corrective lenses, is authorized as a charge to the appropriation, "Medical Department, Navy" only at activities under the management control of this Bureau. These protective goggles should be procured under authority of annual sundry purchase requisition.

(4) Bills, in duplicate, covering the cost of refraction shall be submitted in accordance with articles 20–8 (2) and 20–8 (3).

AIR FORCE*

The United States Air Force is responsible for providing medical and dental care to United States Air Force military personnel on active duty. Military dependents are provided hospitalization and outpatient care in United States Air Force medical facilities whenever practicable and accommodations for their care are available. Air Force personnel should receive medical and dental care at Air Force medical facilities whenever possible. Air Force medical and dental facilities provide medical and dental care to all Air Force military personnel in an adjacent area, even though they are not assigned to the particular Air Force base where the medical and dental facilities are located.

Naturally it is not possible to have USAF medical installations readily accessible to our personnel in every geographical location. In those locations where we do not have such facilities, it is necessary to depend on other governmental or civilian agencies for these services. These agencies include medical and dental services of the Armed Forces (Army and Navy), and other federal agencies, such as the Veterans' Administration and the United States Public Health Service. When medical and dental services of government agencies are not available, civilian medical and dental care may be obtained at no expense to the military personnel concerned, provided such care is obtained in accordance with pertinent Air Force directives. Civilian medical and dental attendance at public expense is authorized for the following Air Force personnel: Nurses; Women Medical Specialists, and other militarized female personnel of the Air Force; officers; contract surgeons (full time); warrant officers; aviation cadets; airmen, when on a duty status or when absent on authorized leave, sick leave, or pass. Civilian medical and dental attendance is not authorized for personnel enumerated when absent without leave. Dependents of active duty military personnel are not authorized civilian medical care at Air Force expense.

All bills for services, including ambulance charges, rendered USAF military personnel by civilian physicians and dentists, or medical facilities will include:

1. Full name, rank, service number and organization to which assigned for duty.
2. Duty status of patient, if known, i.e., duty, leave, or informal leave (pass).
3. Inclusive dates of treatment if hospitalized, otherwise, date and place of treatment.
4. Diagnosis.
5. Charges (itemized separately for services, drugs, x-rays, etc.).
6. A statement certifying that the bill is correct and just; that payment has not been received; that the services rendered and the medicine furnished were necessary; and that charges do not exceed those customary in the vicinity.

Payment for medical and dental service properly submitted from civilian sources to USAF military installations will be accomplished promptly after receipt of necessary authenticated vouchers. The civilian physician or dentist is advised to send the bill for services rendered directly to the Commanding Officer of the nearest Air Force Base.

* From Department of the Air Force, Washington 25, D. C., 12 July 1951.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 166.105, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

State Board of Health Services and Communicable Disease Rules

MEMBERS OF THE WISCONSIN STATE BOARD OF HEALTH. Seated, left to right: Stephen E. Gavin, M. D., Fond du Lac, president; Carl N. Neupert, M. D., Madison, secretary; Samuel Henke, M. D., Eau Claire, vice-president; Stephen Cahana, M. D., Milwaukee; Carl D. Neidhold, M. D., Appleton. Standing, left to right: W. T. Clark, M. D., Janesville; Forrester Raine, M. D., Milwaukee; Woodruff Smith, M. D., Ladysmith; and E. H. Jorris, M. D., Madison, assistant state health officer.

AN OVER-ALL VIEW

THE official Board of Health has the responsibility for determining the policies to be followed by the department and for the approval of programs to be developed or in operation. Its seven members are appointed by the governor with the consent of the senate for seven year terms. The Board elects a secretary, who is also the State Health Officer.

Powers of the Board include that of making and enforcing rules and regulations, holding hearings, and issuing orders on subjects under its jurisdiction as established by Statute.

The work of the Board and of the department is supplemented by local boards of health and health officers in all towns, villages, and cities of Wisconsin. The staffs of the nine district health offices keep in touch with the local boards and officers and assist them in any problem that may arise.

The various bureaus, divisions, and units of the department are organized into five main sections. Their activities are described very briefly on the following pages.

FUNCTIONS AND ACTIVITIES

Section on General Administration

Division of Administration, under the general direction of the State Health Officer, is responsible for organization, direction, and coordination of all of the activities of the State Board of Health. This includes formulation of departmental policies, direction of staff conferences and committee activities, and evaluation and interpretation of departmental policies. The division provides consultation and assistance to other divisions on budget preparation in relation to approved program plans; establishes expenditure controls and provides general supervision over all expenditures; and assists in the preparation and presentation of budget justifications and budget presentations.

Division of Staff Services coordinates major operational services to provide for the effective use of personnel, materials, funds, equipment, and business methods. Subdivisions include:

(1) *Division of Personnel* represents the State Board of Health with the Bureau of Personnel on

all matters related to the recruiting, selection, classification, promotion, dismissal, etc., of employees of the department, including the Wisconsin State Sanatorium and Lake Tomahawk State Camp, numbering approximately 450 employees; where requested, studies, analyzes, and makes recommendations on matters related to internal office procedures and techniques and recommends revisions in organization structure or complement; on request, conducts surveys for local full-time health departments to establish appropriate salary schedules and classification systems and submits recommendations calculated to improve the effectiveness of office management and personnel utilization; and assists localities on request in the recruitment of personnel in categories where the market is in short supply.

(2) *Division of Internal Services* includes the central mail and stock rooms; addressographing; the central collection of fees and the issuances of licenses; and duplicating services.

(3) *Division of Fiscal Services* prepares state and federal budgets, payrolls, and audits expenditures for all funds; estimates receipts and expenditures for inclusion in request to the state legislature for funds; maintains records of all appropriations, allotments, and receipts and expenditures of the department and those covering the state tuberculosis sanatorium at Statesan and the Rehabilitation Camp at Lake Tomahawk. In addition, it audits the reports of the county tuberculosis sanatoria for payment of state aid.

(4) *Division of Statistical Services* provides tabulating and statistical service to all of the sections and divisions of the State Board of Health. Original reports and documents checked and coded in the various divisions are routed to the statistical service division for machine processing, statistical tabulation and analysis. These tables and analyses are referred to the divisions concerned for final interpretation and are then used in program planning on state and local levels.

Division of Laboratories—In 1953 the State Laboratory of Hygiene will move into a new building which is nearing completion on the University of Wisconsin campus. Tests will continue to be made for licensed physicians, veterinarians, health officers, and health commissioners without charge. Some of the specific tests conducted are those to detect the presence of tubercule bacilli, gonococci, meningococci, typhoid and paratyphoid organisms, and ova and cysts of parasites; and those to detect diseases such as rabies, actinomycosis, tularemia, and undulant fever.

The laboratory will also prepare typhoid and paratyphoid vaccines and produce other biologic agents which may be used in the control and prevention of disease.

After moving into the new building, the laboratory will extend its program to include such services as various tests for the recognition of virus diseases; laboratory tests required in special epidemiologic studies; examinations for the recognition of various fungi, parasitic diseases of the intestinal tract, and serologic and cultural tests for the recognition of amoebic dysentery and other diseases where these tests will be applicable.

The state branch laboratory at Rhinelander and the various cooperative laboratories will be discontinued as of July 1, 1953. In some instances, the city will take over a laboratory and operate it. In other instances the county will join with the city. These city or city-county laboratories will be primarily occupied with tests concerning the sanitation of milk, water, and other foods. They will also do tests that are needed in connection with the city

A new building for the State Laboratory of Hygiene is nearing completion on the University of Wisconsin campus.

health department activities such as restaurant sanitation.

The work previously done in these laboratories will be forwarded to Madison. This includes the examination of samples of water submitted from municipalities, state parks, trailer camps, summer resorts, and other public and private agencies.

Bureau of Vital Statistics—Vital records of birth, death, marriage, and divorce filed with the Bureau of Vital Statistics fill two essential needs. They provide a legal document for proof of age, identity, relationship, citizenship, etc., so frequently required as a part of our every day life for inheritance, job applications, military service, and old age and social security benefits. These vital records also serve as the basis, after tabulation and analysis, for program planning in public health and the evaluation of programs already under way. They constitute the bookkeeping of public health.

The Division prepares and distributes birth, stillbirth, death, and marriage forms and collects these records from 71 county registers of deeds and 161 city health officers who are designated as "local registrars of vital records," and who, in turn, receive most of the original records from the physician in attendance. It also collects reports on divorces and adoptions from the courts of the state.

It classifies the social and medical information on these records for machine tabulation in conformity with rules governing the International Registration Area. It thus makes available to the individual concerned essential, permanent, legal documentation upon request, for a nominal fee. It supplies to a wide variety of interested people, organizations, and governmental agencies demographic and public health information of indispensable value.

Division of Dental Education plans and directs a state-wide program of dental health education and research; conducts controlled studies of the effects of fluoridation of water in the prevention of dental caries; and at present is demonstrating the topical application of fluorides to teeth in certain areas in the state. As of December 1, 1952 there were 83 cities in Wisconsin fluoridating their public water supplies. They include: Alma, Amery, Antigo, Appleton, Ashland, Athens, Baraboo, Beaver Dam, Belleville, Beloit, Berlin, Blair, Bloomer, Boscobel, Cambridge, Cedar Grove, Columbus, Crestwood, De Forest, Eagle River, Eau Claire, Edgar, Edgerton, Elkhorn, Elroy, Evansville, Fond du Lac, Fort Atkinson, Galesville, Hartford, Hayward, Horicon, Janesville, Lake Geneva, Lodi, Madison, Marinette, Marshfield, Mayville, Mazomanie, Menasha, Menomonee Falls, Middleton, Mineral Point, Mount Horeb, Mukwonago, Neenah, Neopit, New Glarus, Oregon, Orfordville, Oshkosh, Phillips, Platteville, Portage, Port Washington, Poynette, Prairie du Sac, Racine, Reedsburg, Rhinelander, Rice Lake, Richland Center, Ripon, Sheboygan, Shell Lake, Soldiers Grove, South Milwaukee, Sparta, Spooner, Spring Green, Stoughton, Sun Prairie, Tomahawk, Trempealeau, Watertown, Waunakee, Waupun, Wausau, West Bend, Westby, Whitehall, and Wisconsin Rapids.

Division of Health Education provides special assistance in health education activities for all sections and the district offices; promotes and develops health education activities in local health departments and in official and non-official agencies interested in health.

Movies and filmstrips on health subjects are loaned to schools, public health agencies, clubs, and other groups throughout the state.

Articles on health subjects are prepared and submitted to the Wisconsin press. The bimonthly bulletin, "Health," the Biennial Report, and other reports are edited, and pamphlets are prepared.

Health educators with special training in sex education assist communities in the development of local social hygiene programs. They help schools in integrating social hygiene into the curricula and lead discussions with boys and girls.

In cooperation with safety councils, publications, visual aids, and other materials on home safety are made available to local communities to use in developing their own programs for the prevention of home accidents.

Division of Hospital and Related Services inventories existing hospitals (general and allied, chronic disease, mental, tuberculosis sanatoria, public health centers, and related facilities), including public, non-profit, and proprietary hospitals; surveys the need of such public and other non-profit hospitals as will afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all of the people of the state. The state act has set up an advisory hospital council to assist and consult in the development of the state plan.

Approximately 60 per cent of the federal funds are allocated for general hospital facilities; the remaining 40 per cent for other categories of facilities. The plan establishes a list of priorities for 73 areas of the state for the approval of general hospital projects. The order of priority is based primarily on the relative need for hospital facilities, although special consideration is given to rural areas and areas with low financial resources.

Applications are received up to and including the beginning of each fiscal year, starting July 1. Projects are approved shortly thereafter within the limitation of federal funds available. Thirty-nine projects have already received initial or final approval during the first six years of the program. Thirty-two are for 1,385 general hospital beds. The remaining seven are for other categories: chronic disease, one; psychiatric, two; combination chronic and psychiatric, three; and a new state laboratory of hygiene building. The 39 projects have absorbed all of the federal aid available during the first six fiscal years of the program.

Wisconsin's share of the annual federal allotment amounts to approximately $1,500,000. The state

plan provides that 55 per cent of the construction costs be borne by the applicant. Applications for federal grants-in-aid and other detailed information may be obtained from the State Board of Health, Division of Hospital and Related Services, State Office Building, Madison 2, Wisconsin.

NURSING HOMES. The division is responsible for the registration, licensure, inspection, and regulation of nursing homes, including boarding and convalescent homes for the aged, infirm or chronically ill, proprietary, nongovernmental or governmental, except county institutions subject to the supervision of the State Department of Public Welfare under sections 46.16 (1) and 46.17 (1) of the statutes.

An advisory committee consisting of the state health officer and the director of the state department of public welfare, or their designated representatives, and seven additional members including persons of recognized ability in the fields of hospital administration, nursing home operation, medicine, nursing, social services, and persons with broad civic interests representing the general public advises and consults in the establishment and review of minimum standards and rules and regulations for such homes.

License is required for the reception and *care or treatment* not less than 72 hours in any week of three or more *unrelated* individuals, who by reason of aging, illness, blindness, disease or physical or mental infirmity desire such service.

Division of Barbering enforces state laws governing barbering and examines and licenses all persons engaged in barbering.

Division of Funeral Directing and Embalming enforces state laws governing funeral directors, embalmers, apprentices, and funeral establishments; registers apprentices and supervises the training program; examines and licenses all funeral directors and embalmers; licenses funeral establishments.

Division of Cosmetology enforces the state law governing cosmetology by inspection and investigation; examines and licenses all cosmetologists; registers apprentices in beauty salons and students in schools of cosmetology; licenses beauty and electrolysis salons and schools of cosmetology.

Section on Maternal and Child Health

Bureau of Maternal and Child Health directs its activities to programs and services that will reduce maternal and infant deaths and prevent physical and emotional illness. It studies and interprets statistical information from birth and death certificates in order to keep professional and lay persons throughout Wisconsin informed on special needs. Assistance is made available to local communities in planning and carrying on health activities for expectant mothers and children and in providing on-the-job training of staff and professional groups. Literature on prenatal, infant, and child care, including a prenatal letter service, is prepared and provided for educational purposes.

Physicians may borrow health films without charge from one of the largest selections of public health films in the country.

OBSTETRIC AND PEDIATRIC EDUCATION is carried on with the State Medical Society through joint projects such as lectures, courses or special studies.

NURSING CONSULTANTS work through the district offices and directly with hospitals and public health and social agencies to help communities establish more adequate services for mothers and children. They assist in interpreting community needs; in carrying on staff education; in demonstrating technical phases of nursing care; and in organizing parent education projects. Effort is made to coordinate the work of the public health and hospital nurses and to encourage referral of patients by the medical profession. Incubators are placed in strategic hospitals to assist them in providing more adequate care of the immature and newborn infant.

SCHOOL HEALTH. Consultant service is provided school administrators, supervisors, classroom teachers, teacher training institutions, and public health personnel by the school health consultant. The Wisconsin Cooperative School Health Plan is encouraged in all school systems in the state. The Medical Society is represented on the State School Health Council and also has a School Health Committee which offers advice on new plans and projects for improving physical and mental health.

Emphasis is placed on routine health supervision of preschool and school children by the family physician. Health series Bulletin No. 8, "School Health Examinations," was revised in 1951. It outlines for physicians and school personnel recommended procedures and prescribed forms.

Increased emphasis is placed on the physical fitness and health examinations of school personnel. Sec. 40.16 (14) Wisconsin Statutes, which enables school boards to require periodic health examinations, including chest x-rays of all persons working with school children, has resulted in extension of this important program.

Physicians may obtain from school superintendents or from the State Board of Health sample copies of the recommended forms for examination of school personnel or preschool and school children.

Division of Child Guidance organizes educational and clinical programs in preventive aspects of mental health; demonstrates and supervises local community guidance centers; cooperates in training center for specialists in this area; participates in postgraduate medical education in preventive psychiatry and in-service training programs for public health workers, teachers, social workers; carries out programs of lay education through all media; acts in advisory capacity on mental health matters to organizations and agencies; conducts studies on mental health programs; promotes and encourages local projects in community mental health education; provides physicians with bulletins, films on child problems; is affiliated with the University of Wisconsin to provide facilities for teaching psychologic aspects of child health care.

Local Preventive Mental Health Services

Brown County Child Guidance Center, 319 East Walnut Street, Green Bay; Elizabeth D. Kane, M. D., Director

Dane County Child Guidance Center, 427 State Street, Madison: Leland K. Reek, M. D., Director

Dodge County Child Guidance Center, Court House, Juneau: Vacancy

Douglas County Child Guidance Center, City Hall, Superior: Lawrence R. Gowan, M. D., Director

Fond du Lac County Child Guidance Center, Court House, Fond du Lac: C. J. Buscaglia, M. D., Director

Jefferson County Child Guidance Center, Court House, Jefferson: Hertha Tarrasch, M. D., Director

Kenosha County Mental Hygiene Clinic, 5619 Sixth Avenue, Kenosha: Harold T. Schroeder, M. D., Director

La Crosse County Child Guidance Center, 419 Newburg Bldg., La Crosse: C. F. Midelfort, M. D., Director

Manitowoc County Child Guidance Center, 1010 South 7th St., Manitowoc: Keith Keane, M. D., Director

Milwaukee County Guidance Clinic, Public Safety Building, Milwaukee: Sara Geiger, M. D., Director

Racine County Guidance Clinic, City Hall, Racine: Harold T. Schroeder, M. D., Director

Rock County Child Guidance Center, 26 South Bluff Street, Janesville: Hertha Tarrasch, M. D., Director

Sheboygan County Guidance Clinic, 211 Security National Bank Building, Sheboygan: Keith Keane, M. D., Director

Twin City Child Guidance Center, V.N.A. Headquarters, Neenah: Elizabeth D. Kane, M. D., Director

Walworth County Child Guidance Center, Court House, Elkhorn: George Weber, M. D., Director

Waukesha County Child Guidance Center, Court House, Waukesha: Owen Otto, M. D., Director

Wisconsin University Hospitals, Central Child Guidance Service, Madison: Eugenia S. Cameron, M. D., Director

The Division of Nutrition is responsible for developing a program for nutrition improvement so that people at all age levels may have the foods needed to maintain good health. A staff of nutritionists, who also are qualified, experienced dietitians, provide a variety of services: They visit small hospitals and nursing homes to assist the administrator and medical staff in developing good dietary standards and in planning for special diet needs. They aid in planning adequate facilities for kitchen and food service units in new or remodeled buildings.

The nutritionists work with professional personnel in local health, welfare and educational agencies. They assist directors of children's institutions and camps in planning for more adequate food. In schools, they work with administrators to improve the quality of school lunches and to utilize the lunch program as a means of developing better food habits. They provide teachers with basic nutrition facts and guide them in planning nutrition education activities. Through pamphlets, newspaper releases, radio talks and community group discussions, the public is further provided with up-to-date nutrition information.

Section on Environmental Sanitation

This section exercises general supervision and guidance over public health engineering activities in the state.

Bureau of Sanitary Engineering has specific functions described under the following headings:

PUBLIC WATER WORKS.—Maintains general supervision over the installation and operation of public water supplies, including the approval of plans and specifications for contruction; interstate carrier water supply certification in cooperation with the United States Public Health Service; promotes new systems.

PUBLIC SEWAGE WORKS.—Supervises the installation and operation of public sewage systems, including the approval of plans and specifications for construction; and promotes new systems.

MILK SANITATION.—Promotes adoption of uniform ordinances and codes and enforcement thereof, cooperates with the Department of Agriculture in supervising and certifying milk products for interstate or intrastate shipment, and recommends certification of milk used on common carriers.

GENERAL SANITATION.—Supervises sanitary control over swimming pools and beaches, camps (recreational, industrial, trailer), garbage and refuse disposal, atmospheric pollution control, and other miscellaneous sanitation activities; certifies industrial camps.

Division of Plumbing licenses plumbers; enforces the state plumbing code; promotes adequate plumbing and sanitation in rural and urban areas, including the approval of plans for comfort stations and lake and stream plots.

Division of Well Drilling registers well drillers; administers the pure drinking water law and the state well construction code, issues permits on high capacity wells and supervises ground water developments.

Division of Rendering and Slaughtering inspects and licenses; approves sites and plans for new construction; promotes improved operation of plants.

Division of Water Pollution Control conducts pollution surveys; studies trade wastes and other pollution abatement measures, conducts routine and special stream surveys, conducts cooperative studies with industries, supervises aquatic nuisance control procedures, and renders other services for the State Committee on Water Pollution.

Section on Local Health Administration

This section is concerned with planning, organizing, and supervising the activities of the district offices, county, city-county, and multiple county health departments, and other bureaus and divisions in the section.

Division of Local Health Administration plans for, and assists in, the development of full-time city-county, county, and multiple county health departments throughout the state. It advises and assists local health officials in the 1,800 health districts through the nine district health offices. Help is given to local health departments in evaluating and directing their programs; making surveys and studies of local needs; securing financial aid; preparing budgets for local health departments; and planning and promoting a continuous program of professional education for public health personnel.

Nine District Health Offices. The state has been divided into nine districts by the State Board of Health, with a full-time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer, and secretary make up the staff in each office. A few of the districts have additional public health personnel, such as a nutritionist, dental hygienist, or health educator. Many of the districts have been assigned a hotel and restaurant inspector and a stream pollution engineer. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing, or sanitation. Maternity hospitals are inspected.

Bureau of Public Health Nursing gives consultant services to public health nurses and to public and voluntary health organizations regarding public health nursing policies and administration. It studies and analyzes reports of local public health nurses and prepares manuals, guides, records, and report forms to aid the local nursing services in guidance of local programs. A register of public health nurses is maintained, and credentials of qualified applicants are supplied to any employing body. It plans, encourages, and participates in continuous staff education programs for state, district, and local public health nursing staffs. It assigns and supervises rural field experiences for public health nursing students.

Division of Industrial Hygiene makes studies to determine whether workers in all types of industries are exposed to poisonous dusts, fumes, vapors, or gases. If harmful exposures are found, recommendations for control are made to the management. The division provides nursing consultation and assistance in planning a part-time or full-time industrial nursing service and promotes medical programs that include physical examinations (pre-employment and periodic re-examinations). Annual clinics for practicing physicians are organized on industrial health and safety problems. Research is conducted to develop new equipment and methods to evaluate the potential health hazards associated with the use of new industrial chemicals. This division works closely with the State Industrial Commission and other state departments to carry out an effective program.

Division of Hotels and Restaurants inspects and recommends proper sanitary conditions in hotels, restaurants, and other licensed places that serve food to assure the public of good wholesome food properly prepared and served, as well as a safe and sanitary environment. Hotels, restaurants, tourist rooms, tourist cottages, tourist cabins, roadside stands, taverns, drug stores or any other permanent place that serves food or furnishes lodging to the general public are licensed by this division. Also licensed are all eating places at fairs, carnivals, or similar gatherings to assure the public that a standard of sanitation and safety is maintained.

This division works with the Plumbing Division, Industrial Commission, local health departments, and other agencies to see that all lodging places or places that feed the general public are properly licensed and inspected for safety and sanitation from year to year. This inspectional work is supplemented by food handling schools conducted throughout the state to cover all phases of proper food handling practices.

Section on Preventable Diseases

With the progress of medical science, many deadly diseases have been reclassified as preventable. This section is engaged in the vital task of keeping public health practices up to date. The basis for this activity is the systematic collection and analysis of morbidity and mortality data, aimed at directing not only administrative practices toward a reduction in the causes of sickness and death but also a retardation in the progressiveness of incurable disease which should be detected as early as possible.

Bureau of Communicable Diseases administers, promotes, and encourages local projects for the prevention of communicable diseases through the agency of the local health officers.

Division of Tuberculosis Control plans and assists in carrying out a comprehensive program aimed at the eradication of tuberculosis. To achieve this, it

operates mobile x-ray units for the systematic mass survey of entire counties, and performs specific duties relative to the finding, treating, and rehabilitating of tuberculous persons. A central register of tuberculosis cases to aid local health agencies in the follow-up of all reported and suspected cases of tuberculosis is maintained.

This division has under its general supervision the activities of the Wisconsin State Sanatorium and Lake Tomahawk State Camp. Wisconsin State Sanatorium is a 241 bed institution which is operated primarily for the treatment of patients with incipient tuberculosis. Lake Tomahawk State Camp provides for the rehabilitation of male tuberculous patients.

Division of Heart Disease Control is developing a program of professional and lay education, community service, and research to reduce morbidity and mortality from heart diseases, the leading cause of death.

Division of Venereal Disease Control maintains information on sources and incidence of venereal diseases; seeks to find and bring under treatment all persons who have venereal disease in a communicable stage; provides follow-up of contacts for private physicians.

Division of Cancer Control encourages early diagnosis, adequate treatment, and follow-up of cancer patients; prepares statistical studies of case reports as a part of this program; cooperates with state and local medical and dental societies, state universities, the Wisconsin Division of the American Cancer Society, and other interested agencies and persons in conducting postgraduate, medical and lay education programs.

COMMUNICABLE DISEASE RULES

CD 1.00 Communicable Diseases

The following are declared to be communicable diseases and the control measures for each specific disease shall be as herein provided. All reasonably suspected cases of communicable diseases shall be regarded as actual cases until proved otherwise and all rules and regulations applicable to actual cases shall be applied to them.

CD 1.01 Actinomycosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None, provided the patient is under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from lesions and articles soiled therewith. (2) Terminal disinfection by thorough cleaning.

CD 1.02 Amebic Dysentery

A. Patient: (1) Placard: None. (2) Restrictions: Isolation—none. No person having amebic dysentery, or who is a carrier of amebic dysentery, shall handle, prepare, or serve food for public consumption until completion of treatment and three negative stool tests, taken not less than one day apart, are obtained. (3) Reporting: All cases and carriers of amebic dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine—none. Contacts within the home are prohibited from handling or preparing food for public consumption until 2 negative stool tests, on consecutive days, are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and

COMMUNICABLE DISEASES

Summary of Rules

Disease	Reportable	Isolation Patient	Restriction Contact	Placard
Actinomycosis	Yes	None if under medical care	None	None
Amebic dysentery	Yes	Food handling restricted	Food handling restricted	None
Anthrax	Yes	Until lesions healed	None	None
Bacillary dysentery	Yes	Food handling restricted	Food handling restricted	None
Brucellosis	Yes	None	None	None
Chickenpox	Yes	7 days from onset	None	None
Cholera	Yes	14 days or negative stools	5 days or negative stools	Yes
Diarrhea of the newborn	Yes	Special; see rule	See rule	None
Diphtheria	Yes	10 days and negative cultures	5 days and negative cultures	Yes
Encephalitis	Yes	7 days from onset	None	None
German measles	Yes	7 days from onset	None	None
Hemorrhagic jaundice	Yes	None	None	None
Hepatitis, infectious	Yes	7 days from onset	None	None
Histoplasmosis	Yes	None	None	None
Leprosy	Yes	Yes; see rule	None	None
Malaria	Yes	Until blood negative for parasites	None	None
Measles	Yes	7 days from start of rash	Susceptibles: 7 days beginning 2nd week exposure	None
Meningitis, meningococcal	Yes	14 days; see rule	None	None
Mumps	Yes	Minimum 7 days	None	None
Ophthalmia neonatorum	Limited	None if under medical care	None	None
Plague	Yes	Minimum 14 days	In pneumonic form, 7 days last exposure	Yes
Poliomyelitis	Yes	14 days from onset	Intimate contacts only; see rule	Yes
Psittacosis	Yes	During acute stage disease	None	None
Rabies	Yes	None if under medical care	None	None
Rheumatic fever	Yes	None	None	None
Smallpox	Yes	Until disappearance of crusts and scabs	18 days or successful vaccination within 3 days of exposure	Yes
Scarlet fever, septic sore throat	Yes	14 days or negative cultures	Limited; see rule	Yes
Erysipelas, puerperal infection	No	During acute stage disease	None	None
Tetanus	Yes	None	None	None
Tinea capitis	Yes	Limited; see rule	None	None
Trachoma	Yes	None if under medical care	None	None
Trichinosis	Yes	None	None	None
Tuberculosis	By name	Special; see rule	None	None
Tularemia	Yes	None	None	None
Typhoid fever	Yes	7 days after symptoms and negative cultures	Food handling restricted	Yes
Typhus	Yes	During febrile period	Delousing	None
Venereal diseases	Special	None if under medical care	Examination	None
Whooping cough	Yes	28 days from onset	Limited; see rule	None
Yellow fever	Yes	7 days	None	None

vermin-proof by screening or other effective arrangements. (2) Concurrent Disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.03 Anthrax

A. Patient: (1) Placard—None. (2) Restrictions —Isolation until the lesions have healed. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of the discharges from lesions and articles soiled therewith. (2) Terminal disinfection: Thorough cleaning.

CD 1.04 Bacillary Dysentery

A. Patient: (1) Placard—none. (2) Restrictions: Isolation—none. No person having bacillary dysentery, or who is a carrier of bacillary dysentery shall handle, prepare or serve food for public consumption which is not subsequently to be cooked, until completion of treatment and 2 negative stool tests taken not less than one day apart. (3) Reporting: All cases and carriers of bacillary dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine none. Contacts within the home are prohibited from handling or preparing food for public consumption until 2 negative stools are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements. (2) Concurrent disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.05 Brucellosis

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: None. (2) Terminal disinfection: None.

CD 1.06 Chickenpox

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for seven days at home from date of onset. (3) Reporting: All cases are to be reported to the local health officer. The diagnoses of all cases of chickenpox occurring in persons over 15 years of age are to be verified by a physician. Where a physician is not employed by the family, the local board of health is required to furnish a physician for the verification of such diagnosis.

B. Contacts: Restrictions: Quarantine none. Well children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

C. Environment: There is to be concurrent disinfection of all articles soiled by discharges from the nose and throat as well as from the lesions.

CD 1.07 Cholera

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated in a hospital or a well screened room for fourteen days or until the stool is found to be free from cholera vibrio on three consecutive days. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: All contacts are to be quarantined for a period of five days from the date of last exposure and until 2 negative, consecutive cultures are obtained.

C. Environment: (1) Concurrent disinfection. There is to be prompt and thorough disinfection of the stools and vomitus. Articles used by and in connection with the patient are to be disinfected. Food left by the patient is to be burned. (2) Terminal disinfection: The room in which a patient was isolated is to be thoroughly cleaned.

CD 1.08 Diarrhea of the Newborn

A. Patient: (1) Placard none. (2) Restrictions: Immediate removal of affected baby from nursery to isolation ward. Closure of contaminated nursery to new admissions and suspension of maternity service. (3) Reporting: The occurrence of any case of diarrhea of the newborn is to be immediately reported to the local health officer in those communities which employ a full-time health officer. In those communities where a full-time health officer is not employed, the occurrence of diarrhea of the newborn is to be reported directly to the Wisconsin State Board of Health.

B. Contacts: Restrictions: All exposed babies in the nursery are to be cared for by separate medical and nursing personnel.

C. Environment: (1) All articles within the nursery are to be disinfected as thoroughly as practical. (2) Terminal disinfection—thorough cleansing of the premises.

CD 1.09 Diphtheria

A. Patient: (1) Placarding required. (2) Restrictions: The patient is to be isolated for at least ten days and until 2 consecutive, negative nose and throat cultures, taken not less than twenty-four hours apart, are obtained. (3) Reporting: All cases and carriers shall be reported to the local health officer.

B. Contacts: Restrictions: All intimate contacts are to be quarantined for at least five days and until 2 consecutive, negative nose and throat cultures are obtained. Children in the family with the patient may not return to school until all persons within the affected household have been shown to no longer carry the etiologic agent.

C. Environment: (1) All carriers of diphtheria bacilli are to be handled as cases unless laboratory examination demonstrates that the organisms are not virulent. (2) All articles which have been in contact with the patient and all articles soiled by

discharges of the patient are to be concurrently disinfected.

CD 1.10 Encephalitis

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated in a well-screened room for an interval of seven days from the onset of the disease. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.11 German Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days from onset. (3) Reporting: All cases are to be reported to the local health officer.

B. Contacts: (1) Restrictions: Quarantine none. (2) Other children in the family may attend school but are to be observed by the teacher and excluded if they show evidence of illness.

CD 1.12 Hemorrhagic Jaundice

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Urine and other discharges of patient. (2) Terminal disinfection: None.

CD 1.13 Hepatitis, Infectious

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the first week of illness. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Discharges of nose, throat, and bowels of the patient. (2) Terminal disinfection: None.

CD 1.14 Histoplasmosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.15 Leprosy

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated at home until transferred to a national leprosarium. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges and articles soiled with discharges from the patient. (2) Terminal disinfection: Cleansing of premises after removal of patient.

CD 1.16 Malaria

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room until blood is negative for parasites. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.17 Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days upon appearance of rash. (3) Reporting required.

B. Contacts: Restrictions: Susceptible contacts in the home are to be restricted to the premises beginning the second week after exposure for a period of seven days.

C. Environment: Concurrent disinfection: All articles soiled with secretions of the nose and throat are to be concurrently disinfected.

CD 1.18 Meningitis, Meningococcic

A. Patient: (1) Placard none. (2) Restrictions: Isolation until forty-eight hours after the institution of treatment with a sulfonamide or penicillin. In the absence of such treatment the patient is to be isolated for two weeks. (3) Reporting: The occurrence of meningococcic meningitis is to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: There is to be concurrent disinfection of discharges from the nose and throat or articles soiled with these discharges.

CD 1.19 Mumps

A. Patient: (1) Placard none. (2) Restrictions: Isolation of patient for at least one week or until disappearance of swelling. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none. Other children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

CD 1.20 Ophthalmia Neonatorum

A. Patient: (1) Placard—None. (2) Restrictions —None provided the patient is under adequate medical supervision. (3) Reporting—None except as provided in Sec. 146.01 (2) which requires reporting to the local health officer in cases not attended by a physician or midwife.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of conjunctival discharges and soiled articles. (2) Terminal disinfection—Thorough cleaning.

D. Prevention: The attending physician or midwife is required to place 2 drops of a 1 per cent solution of silver nitrate in each eye of a newborn child immediately after delivery. Failure to observe this requirement is punishable by a fine of not more than one hundred dollars. (Section 146.01)

CD 1.21 Plague

A. Patient: (1) Placard required. (2) Restrictions: Isolation of patient in a hospital or well-

screened room which is free from vermin for a period of at least two weeks. (3) Reporting required.

B. Contacts: Restrictions: Quarantine of persons exposed to the pneumonic form of the disease for a period of one week from the date of last exposure.

C. Environment: (1) Concurrent disinfection of sputum and soiled articles. (2) Extermination of rats and vermin from the premises.

CD 1.22 Poliomyelitis

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for a period of at least two weeks from the onset of the symptoms. (3) Reporting: All cases are to be reported to the local health officer as soon as the diagnosis is established. At the time of release from isolation a second report is to be made for the purpose of verifying the original diagnosis and stating whether the patient was afflicted with a paralytic or nonparalytic form of the disease.

B. Contacts: Restrictions: Intimate contacts under 18 years of age are to be quarantined for two weeks. Intimate contacts who are adults: Teachers and others who come in contact with children and food handlers must cease their occupation for an interval of two weeks.

C. Environment: Concurrent disinfection: All discharges from the nose and throat and bowel are to be concurrently disinfected.

CD 1.23 Psittacosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the febrile and acute clinical stage of the disease. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges. (2) Terminal disinfection—Destruction of infected birds.

CD 1.24 Rabies

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None if the patient is under medical supervision and the immediate attendants are warned of possibility of inoculation by human virus. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of saliva of patient and articles soiled therewith. (2) Terminal disinfection: None.

CD 1.25 Rheumatic Fever (Active)

A. Patient (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.26 Smallpox

A. Patient: (1) Placard required. (2) Restrictions: Isolate until the disappearance of all scabs and crusts. (3) Reporting required.

B. Contacts: Restrictions: Quarantine for eighteen days from date of last exposure unless a successful vaccination has been obtained within three days of exposure.

C. Environment: (1) Concurrent disinfection: No article is to leave the immediate surroundings of the patient without boiling or equally effective disinfection. (2) Terminal disinfection: Thorough cleaning of the premises.

CD 1.27 Streptococcic Diseases, Respiratory Form Scarlet Fever and Septic Sore Throat

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for fourteen days and until suppurative discharges cease. Where laboratory facilities are available, isolation may be terminated after obtaining two consecutive, negative nose and throat cultures, which are not less than twenty-four hours apart. (3) Reporting required.

B. Contacts: Restrictions: Intimately exposed children shall be quarantined to the premises if the contact is not broken. The period of quarantine shall be the same as the period of isolation for the patient. If the contact is broken, the period of quarantine shall be for five days or until two consecutive, negative nose and throat cultures, not less than 24 hours apart, are obtained. Adult contacts are not to be restricted except in the case of food handlers and teachers. Adults engaged in the preparation, handling and serving of food shall not be permitted to engage in the handling of food for an interval equal to the isolation period of the patient if contact is not broken. If contact is broken, food handlers may not engage in the preparation, handling and serving of food for an interval of five days. Teachers intimately exposed in the place of residence shall not attend school or associate with groups of children for five days after exposure.

C. Environment: (1) Concurrent disinfection: All articles which have been soiled by purulent discharges and all articles which have been in contact with the patient are to be concurrently disinfected. (2) Terminal disinfection: A thorough cleaning of contaminated objects, scrubbing of floors and sunning of blankets to prevent dissemination of infected particles.

CD 1.28 Streptococcic Diseases Other Than Respiratory Erysipelas and Puerperal Infection

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for the duration of the acute stage of the disease. (3) Reporting none.

B. Contacts: Restrictions none.

C. Environment: (1) Concurrent disinfection: Careful disposal of dressings and discharges from the patient. (2) Terminal Disinfection: General thorough cleaning of blankets, linen, and room.

CD 1.29 Tetanus

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection—None. (2) Terminal disinfection—None.

CD 1.30 Tinea Capitis (Ringworm scalp)

A. Patient: (1) Placard—None. (2) Restrictions:

Exclusion from school until recovery unless (a) under continuous treatment of physician licensed to practice medicine, and wears a suitable head covering until cured, or (b) separate class room provided for infected patients. (3) Reporting required.

B. Contacts: Upon discovery of a clinical case of ringworm of the scalp, all contacts under 15 and all school children in the classroom should be inspected and examined with suitable filtered ultraviolet light. Resurveys should be continued until one month after last case is detected.

C. Environment: (1) Concurrent disinfection — Stocking caps and inexpensive head coverings should be frequently laundered and destroyed by burning after use. (2) Terminal disinfection—None.

CD 1.31 Trachoma

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None, if under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of eye discharges and articles soiled therewith. (2) Terminal disinfection—None.

CD 1.32 Trichinosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts—No restrictions.

C. Environment: (1) Concurrent disinfection—None. (2) Terminal disinfection—None.

CD 1.33 Tuberculosis

A. Patient: (1) Placard—None.

(2) Restrictions: *(a)* All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:

1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
3. Using individual eating utensils sterilized by boiling after each use.
4. Using separate towels.
5. Sleeping alone.
6. Avoiding coming in contact with other individuals on all possible occasions.
7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.

(b) Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by x-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be isolated on his premises by the local board of health or the health officer on the direction of the State Board of Health or state health officer, or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction.

(c) A placard shall be posted in a conspicuous position on the premises, with the words "communicable disease" in letters not less than two inches high.

(d) The local board of health or health officer may employ as many persons as are necessary to execute its orders and properly guard any patient in isolation if isolation is violated or intent to violate isolation is manifested. Such persons shall be sworn in as guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or for the enforcement of these rules and regulations.

(e) The expense of maintaining isolation, including examinations and tests to determine the presence or communicability of the disease, and the enforcement of isolation on the premises, shall be paid by the city, incorporated village or town upon order of the local board of health. The expenses for necessary nurses, medical attention, food and other articles needed for the comfort of the afflicted person shall be charged against him or whoever is liable for his support. Indigent patients shall be cared for at public expense.

(f) Any individual who has been isolated on the premises under provision of these rules shall be released from such isolation by the local board of health or health officer on direction of the State Board of Health or state health officer or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction when in the opinion of said health officer the isolation is no longer necessary to protect others from becoming infected.

(g) No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

(h) If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be isolated upon his premises as provided in Section (b) if in the opinion of the State Board of Health or the state health officer or of the full-time medical health officer of cities or counties with a popu-

lation of 250,000 or more, agree that isolation is necessary in order to protect others from becoming infected.

(i) The local health officer or an individual delegated by him shall visit all individuals isolated for tuberculosis at least once every 15 days to ascertain that the isolation is being maintained and to ascertain whether to make recommendations for release from isolation or for admission to a tuberculosis sanatorium.

(j) Any individual isolated for tuberculosis may obtain release from such isolation by being admitted to a tuberculosis sanatorium.

(k) Individuals afflicted with tuberculosis in any form and diagnosed as such by a competent physician shall exercise every care and precaution for the protection of others.

(3) Reporting—By name to local health officer.

B. Contacts: No restrictions.

C. Environment: Disinfection: All handkerchiefs, towels, cloths, eating utensils and other contaminated material used by a person with tuberculosis shall receive appropriate disinfection before coming in contact with others. Upon the death or removal of a person with tuberculosis the health officer shall require disinfection of the premises occupied by the patient by a thorough washing of the woodwork by soap and water or a disinfectant, boiling of the dishes and contaminated fabrics, and a thorough sunning of material which can not be subjected to other disinfection.

It is the intent of these rules and regulations to give reasonable protection to the public from exposure to an individual afflicted with pulmonary tuberculosis in the communicable form.

CD 1.34 Tularemia

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from the ulcer, lymph glands, or conjunctival sac. (2) Terminal disinfection—None.

CD 1.35 Typhoid Fever

A. Patient: (1) Placard required. (2) Restrictions: Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces and urine are obtained at least five days apart. (3) Reporting required.

B. Contacts. (1) Quarantine none. (2) Family contacts are not to be permitted to handle food during the period of contact or before two negative, consecutive stool and urine cultures are obtained.

C. Environment: (1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them. (2) Terminal disinfection through a thorough cleaning of the premises. (3) Suppression of flies.

D. Typhoid (Paratyphoid) Carrier:

1. Definition: A person shall be considered a typhoid (paratyphoid) carrier, capable of transmitting the disease to susceptible persons if:

(a) During or following his convalescence from the disease his feces and urine have not been proved free from typhoid (or paratyphoid) bacilli by examination in an approved laboratory (temporary carrier).

(b) He has not suffered from typhoid (or paratyphoid) fever within one year, but typhoid (or paratyphoid) bacilli are found in his urine or feces when examined in an approved laboratory (chronic carrier).

(c) Epidemiologic evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or can not be obtained for examination in an approved laboratory.

2. Rules:

(a) The urine and feces of a typhoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(b) If food products, which are to be consumed raw by others, are produced on premises occupied by a typhoid carrier, the water supply shall be proven free from contamination.

(c) No typhoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employes.

(d) No typhoid carrier shall engage in the occupation of nurse, nurse-maid, domestic servant, cook, waiter, dishwasher, or public eating-house employe.

(e) No typhoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No typhoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(1) That the carrier will not engage in milking or handling of milk, cream or dairy utensils, or enter the house or barn where milk is produced or handled.

(2) That no milk or cream is to subsequently be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(3) That all persons residing or employed on the premises who are susceptible to typhoid shall be vaccinated against typhoid fever at least every three years.

Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(f) No typhoid carrier shall reside in or be employed in a boarding house or camp.

(g) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the State Board of Health of the facts.

(h) In any situation not covered by the above rules and in which a typhoid carrier endangers the public health, the carrier shall observe such recommendations as the State Board of Health may make for the particular case.

3. Release of typhoid carriers:

(a) Following isolation for typhoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens each of urine and feces, passed at an interval of not less than five days, shall have been examined in an approved laboratory and found free from typhoid (or paratyphoid) bacilli; except that if the person is to handle milk, dairy or food products the number of negative cultures shall be four, two of which shall have been examined in the State Laboratory of Hygiene.

(b) A person adjudged a chronic carrier and who has not suffered from typhoid (or paratyphoid) fever within one year may be released from restrictions only on approval of the state health officer, and after certain conditions have been met.

4. Conditions for release of chronic typhoid carriers:

(a) If the gall bladder has not been removed

(1) Three specimens of duodenal contents taken in a hospital at intervals of not less than 24 hours shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, have been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

(b) If the gall bladder has been removed

(1) Subsequent to removal of gall bladder each of three specimens of duodenal contents, taken in a hospital at intervals of not less than 24 hours, shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least six successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, has been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

CD 1.36 Typhus

A. Patient: (1) Placard—None. (2) Restrictions: Delousing, isolation in vermin-free room during febrile period. (3) Reporting required.

B. Contacts—Restrictions: None required if delousing carried out.

C. Environment: (1) Concurrent disinfection—Use of insecticide powders on clothing and bedding and special treatment of hair for nits. (2) Terminal disinfection—None.

CD 1.37 Venereal Diseases

A. The State Board of Health declares the following venereal diseases, namely, syphilis, gonorrhea and chancroid as contagious, infectious, communicable and dangerous to the public health.

B. All Infected Persons Subject to Control.—All persons having venereal disease shall be subject to such control as public safety requires.

C. Who is to Report Venereal Disease.—Any physician who attends, treats or examines a person with venereal disease in communicable form; and any superintendent or manager of a hospital, dispensary, charitable or penal institution having knowledge of any such case not known to be previously reported, shall report such case to the State Board of Health. Such report shall be by designated number, age, sex, conjugal condition and duration of disease. The physician shall inquire into the source of infection and shall report any person known to a reasonable certainty to be the source by name and address to the State Board of Health. Any person knowing of a case of venereal disease not under the care of a physician and believed to be a menace to the public health shall report the name and address directly to the State Board of Health.

D. Reporting of Cases Delinquent in Treatment.—Whenever any person suffering from syphilis, gonorrhea or chancroid in a communicable form shall fail to return to the physician treating such person in reasonable time, such person shall be reported by name and address to the State Board of Health as delinquent in treatment.

E. Examination of Certain Classes Suspected of Having Venereal Disease.—It shall be the duty of each superintendent, manager or physician of any state, county, municipal, charitable or correctional institution, the warden of the state prison, the sheriff and other keepers of any jail or other penal institution to cause an examination to be made of all inmates suspected of having a venereal disease and said examination shall be made by a method satisfactory to the State Board of Health. Vagrants, prostitutes, frequenters of houses of prostitution, and persons guilty of illicit cohabitation are hereby declared to be reasonably suspected to have venereal disease. Any such person found to be infected with any of the venereal diseases in a communicable stage shall be kept in such quarters as not to expose others. Such persons and all legally committed persons with a venereal disease, which is communicable to others, at expiration of commitment shall hereby be considered under quarantine and shall so remain until satisfactory arrangements can be made for care and treatment by a licensed physician at place of sub-

sequent residence or until other disposition of the case is made by the State Board of Health.

F. Isolation.—Whenever a case or suspected case of venereal disease is found on premises where the case cannot be properly controlled during the period of infectiousness, or whenever a case of venereal disease in the infectious stage refuses or neglects care or treatment by a physician licensed to prescribe drugs, or is unmanageable and other persons are endangered, a placard may be placed on the premises occupied by the patient. Such placard shall be applied in emergency and not in lieu of commitment to an institution under Chapter 143.07, Laws of Wisconsin. The placard sign shall have the words "Communicable Disease." Violation of the requirements imposed by the placard shall be deemed a violation of these regulations. The local health officer shall be required by the State Board of Health to impose such isolation and enforce its requirements.

G. Sexual Contacts—Examination of.—All persons reported to be sexual contacts by any person with venereal disease in a communicable form shall be regarded as suspected cases and may be required by an official of the State Board of Health to be examined by a physician in a manner satisfactory to the State Board of Health.

H. Indigents—Treatment Facilities.—Local health officers and local boards of health shall cooperate with the State Board of Health in establishing treatment facilities for indigent persons with venereal disease. Local health officers shall report to the State Board of Health all cases of venereal disease reported to them.

I. Forbidden Occupations.—Persons suspected to be or knowing themselves to be afflicted with a communicable venereal disease shall not engage in the care or nursing of children or of the sick, nor shall they engage in any occupation the nature of which is such that their infection may be communicated to others. In the interests of the public health a medical health officer or officer of the State Board of Health may confidentially inform any person so endangered.

J. Issuing Certificates of Freedom From Venereal Disease Forbidden.—No physician or health officer shall issue certificates of freedom from any venereal disease to any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons or show, for immoral purposes, venereal disease reports from any laboratory. Such procedure is declared by the State Board of Health to be inimical to public health and public welfare.

K. Minors.—The parents or guardians of minors acquiring venereal disease shall, when notified, be legally responsible for the compliance of such minors with the requirements of these regulations.

L. Communicability—Definition of.—All cases of venereal disease shall be regarded as communicable until the following requirements have been met:

1. Syphilis*

Until open sores, ulcers, rashes, syphilitic sore throat or other open syphilitic lesions are healed; and also until satisfactory care and treatment as hereinafter defined has been given to any of the following: Pregnant women with syphilis; females who have given birth to a syphilitic child; syphilitic persons at any stage of the disease who, reasonable evidence indicates, are promiscuous in sexual relations and are a menace to others; and persons with early syphilis not adequately treated.

Adequate treatment shall be considered to be the administration of not less than twenty doses of arsenicals and twenty doses of heavy metal or equally effective treatment by a physician licensed to prescribe drugs. This other effective treatment shall be such as considered adequate by the State Board of Health.

2. Gonorrhea

A. Male:

1. Freedom from discharge.
2. Clear urine, no shreds.
3. Urethral smears must be negative for gonococci on four successive examinations at intervals of not less than one week.
4. Prostatic smears negative to gonococci on two successive tests not less than one month after conclusion of specific treatment.
5. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

B. Female:

1. No unusual vaginal discharge.
2. Two successive negative examinations for gonococci of the secretions of the urethra, vagina and of the cervix with an interval of at least forty-eight hours, and repeated for four successive weeks.
3. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

The labia should be held apart and a swab applied so as to express any secretions from Skenes or Bartholin's glands, which is then taken up on the swab.

In preparing urethral slides the finger should be inserted in the vagina and expression made on the floor of the urethra from within outward, the cotton-tipped probe being then introduced well into the meatus. In procuring a smear from the cervix a vaginal speculum should be introduced and the cervix well exposed. All secretions should be mopped away from the external os before taking the smear. After the cervix is well dried a probe tightly wound with cotton should be inserted in the cervical canal and rotated several times.

---

* Note: Does not apply to Section 143.07, subsection 4.

3. Chancroid

Until all lesions are healed.

CD 1.38 Whooping Cough

A. Patient: (1) Placard none. (2) Restrictions: Isolation for three weeks after onset of typical paroxysms, or a total of twenty-eight days from onset of the catarrhal stage. (3) Report required.

B. Contacts: Restrictions: Other children in the family may attend school but are to be observed by the teacher and excluded if they evidence any symptoms of illness. Those children exposed to whooping cough who develop coughs or colds must be kept in isolation in their home until a diagnosis is established.

C. Environment: (1) Concurrent disinfection of the discharges from the nose and throat and of articles soiled with such discharges. (2) Terminal disinfection. A thorough cleaning of the premises.

CD 1.39 Yellow Fever

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room for seven days. (3) Reporting required on all cases to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent Disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 2.00 Reporting

All communicable diseases which are designated as reportable under these rules shall be reported by all physicians and other persons having knowledge of such diseases to the local health officer and by the local health officer to the State Board of Health unless otherwise specifically provided.

CD 3.00 Definitions

3.01. *Case.* A person whose body has been invaded by an infectious agent, with the result that symptoms have occurred.

3.02. *Carrier.* A person who harbors a specific infectious agent without demonstrating symptoms or signs of the disease.

3.03. *Contact.* A person who has been intimately in contact with an infected person, such as the daily contact of a patient with his parents, his brothers and sisters, other occupants of the home and the like.

3.04. *Isolation.* By isolation is meant the separation of cases or carriers from other persons in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent to susceptible persons.

3.05. *Quarantine.* By quarantine is meant the limitation of freedom of movement or isolation of contacts who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease to which they have been exposed.

3.06. *Disinfection.* Disinfection denotes the destruction of infectious agents by chemical or physical means. In general, two types of disinfection are employed:

A. *Concurrent.* Disinfection carried on continuously during the illness of the patient, such as destruction by use of chemical or physical means of discharges of the patient and cleaning of any infectious material which has come into contact with the patient or may have been soiled by him.

B. *Terminal.* The elimination of the infectious agent from personal clothing, belongings, and the immediate physical environment of the patient.

CD 4.00 Enforcement

It shall be the duty of the health officer of every local board of health in this state to enforce the rules of the State Board of Health covering communicable diseases or a suspected case of communicable disease whenever a case is reported or becomes known to him within his jurisdiction.

CD 5.00 School Attendance (formerly Rule 17)

All teachers, school authorities, and health officers having jurisdiction shall not permit the attendance in any private, parochial or public school of any pupil afflicted with a severe cough, a severe cold, itch, scabies, lice or other vermin, ring worm, impetigo, epidemic jaundice, Vincent's angina (trench mouth), infectious conjunctivitis (pink eye), or any contagious skin disease, or who is filthy in body or clothing, or who has any communicable disease so designated by the State Board of Health unless specifically exempted in the rules. The teachers in all schools shall, without delay, send home any pupil who is obviously sick even if the ailment is unknown, and said teacher shall inform the parents or guardians of said pupil and also the local health officer as speedily as possible, and said health officer shall examine into the case and take such action as is reasonable and necessary for the benefit of the pupils and to prevent the spread of infection.

Parents, guardians or other persons having control of any child who is sick in any way, or who is afflicted with any disease covered by this rule, shall not permit said child to attend any public, private or parochial school or to be present in any public place.

CD 6.00 Sale of Milk and Dairy Products From Infected Home Restricted

The sale or use of milk or dairy products from a place where cholera (Asiatic), diphtheria, poliomyelitis, plague, scarlet fever, smallpox, or typhoid fever is found to exist is strictly forbidden unless the milk is handled, milk utensils washed and stock

cared for and the product transported by persons entirely disassociated from the quarantined family.

CD 7.00 Release Cultures

Where release cultures are required in communicable diseases, such cultures shall be examined in a laboratory approved by the State Board of Health.

CD 8.00 Transporting Patients

When it is necessary to transport a person suffering with a dangerous communicable disease from one town, village or city to another, the consent of the health officer where the patient lives and also the health officer of the town, village or city to which the patient will be transported must first be obtained. Transportation must be made by private conveyance and proper precautions exercised to prevent needless exposure of all persons who may come in contact with the patient during transit.

CD 9.00 Exclusion From School, Assemblages, and Public Conveyances

No person suffering from any communicable disease so designated by the State Board of Health shall be admitted to any public, parochial or private school, college or Sunday school, or shall enter any theatre, assemblage, or railway car, street car, vessel or steamer, or other public conveyance, except as specifically provided in the communicable disease rules.

CD 10.00 Mail in Placarded Home

No mail or other materials shall be sent from a placarded home unless such mail or materials have been prepared and disinfected under the direction of the local health officer.

CD 11.00 Books Not to Be Taken Into Infected Homes

Schoolbooks or books from public or circulating libraries shall not be taken into any house placarded for communicable disease and if schoolbooks or library books have already been taken in such house they shall be destroyed by the owner or library authorities or thoroughly disinfected.

Disinfection of books—In cases where it is desirable to disinfect books which may have become infected with dangerous communicable disease the following requirements must be followed:

Library books which have been in a placarded home should be withheld from circulation for a period of fifteen days and so arranged each day that the sunlight can reach the maximum number of surfaces.

Books used by a tubercular person should either be destroyed or withheld from circulation for at least one month and during this time kept standing in the sunlight opened so that the rays of the sun can reach the maximum number of pages. Surfaces should be changed from day to day. Time and sunlight are recommended as the best means to accomplish the destruction of infectious material deposited upon books.

CD 12.00 Public Funerals Prohibited

12.01. Public or church funerals shall not be held for persons dead of smallpox. Every person who attends the funeral, including members of the family, shall, within 24 hours of attending the funeral or exposure, submit to vaccination for smallpox or produce evidence from a physician of successful vaccination within the past two years.

12.02. Whenever death is due to cholera (Asiatic), diphtheria, poliomyelitis, plague, or scarlet fever, the household and family contacts of the deceased shall not be permitted to attend public or church funerals for the deceased nor to have any association with the public until the specific restrictions governing contacts have been fulfilled.

12.03. The above rules shall apply to funerals of those dead from suspected cases as well as diagnosed cases of the diseases above specified, but shall not apply to those dying from late complications of such diseases after the communicable period is past, and after the family is released from quarantine.

12.04. During periods of epidemic, diseases of any nature found sufficiently malignant to justify private funerals and in the case of death from unusual forms of virulent disease, apparently communicable in nature, the local board of health with the consent of the State Board of Health may prohibit public funerals of those dead from such diseases.

CD 14.00 Food Poisonings

All instances of food poisoning or suspected food poisoning, in which there is reason to believe that the purchase or consumption of the incriminated food occurred at a store or eating place accessible to the general public, shall be reported.

BOOKLET ON "HEART DISEASE IN CHILDREN" NOW AVAILABLE

The American Heart Association and its affiliated heart associations throughout the country have begun distribution of a new booklet, "Heart Disease in Children."

The booklet is intended for parents, teachers, and all others concerned with the problems of child health and child care. It is recommended to physicians to use with parents of patients.

This booklet presents an up-to-date summary of the information now available on the prevention and treatment of rheumatic fever, the treatment of rheumatic heart disease, and the correction of congenital heart defects.

The booklet may be obtained from the Wisconsin Heart Association, 642 North 5th Street, Milwaukee 1, Wisconsin.

THE MEDICAL FORUM

PART OF TRUMAN REPORT CALLED COMPULSORY MEDICINE

WISCONSIN PHYSICIANS snapped at the AMA Clinical Session in Denver last month were, top, left to right, Drs. S. E. Gavin, Fond du Lac and D. H. Witte, Milwaukee, Wisconsin delegates, talking with Dr. Hans Reese, Madison, delegate from the section on nervous and mental diseases. Center left, Dr. E. J. McCormick, Toledo, AMA president-elect, is shown with Dr. J. C. Griffith, Milwaukee, president of the State Medical Society. Center right Dr. Gunnar Gundersen, LaCrosse, of the AMA Board of Trustees was snapped with Dr. James R. McVay, Kansas City, Mo., chairman of the AMA Council on Medical Service in the background. Lower left, Mr. C. Joseph Stetler, Chicago, secretary of the AMA Council on National Emergency Medical Service, chats with Dr. James C. Sargent, Milwaukee, chairman of the council. Lower right, Drs. A. F. R. Andresen, New York and W. D. Stovall, Madison, Wisconsin delegate, attend Reference Committee on Medical Education and Hospitals.

Chicago, December 18.—Dr. Louis H. Bauer, president of the American Medical Association, spoke out strongly today against one of the major recommendations of the President's Commission on the Health Needs of the Nation.

This recommendation, according to Dr. Bauer, provides that "the federal government, through payroll deductions, would pay directly for the medical care of a large segment of the population. "This," he added, "is national compulsory health insurance."

The American Medical Association is withholding comment on the full report of the commission pending careful study of the document by a four-man committee appointed by the Board of Trustees.

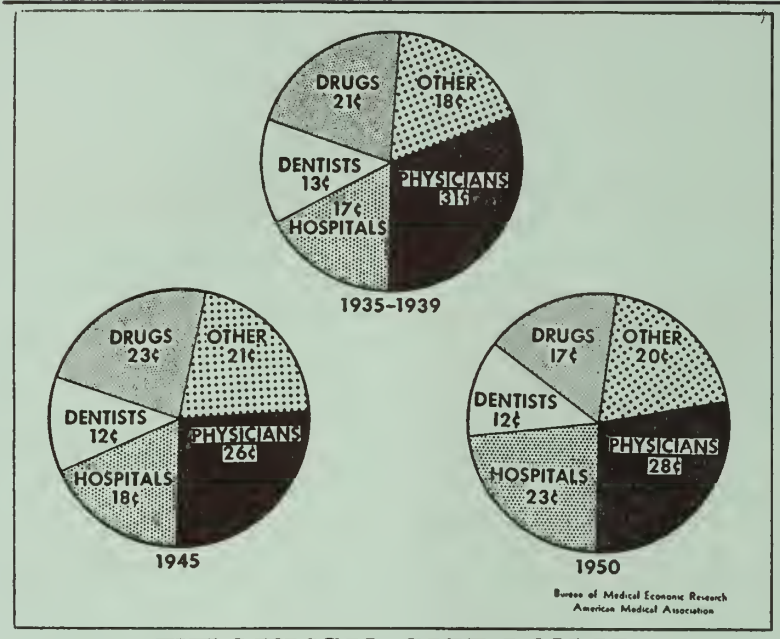
Dr. Gunnar Gundersen, La Crosse, has been chosen to serve on this committee along with Drs. Edwin S. Hamilton, Kankakee. Illinois; Walter B. Martin, Norfolk, Virginia and Bauer. Dr. Gundersen was asked to be a member of the President's Commission on the Health Needs of the Nation when it was set up, but declined the appointment. The four-man committee has not yet had an opportunity to study all of the commission's material.

This material has not yet been made public, but the State Medical Society will review it as soon as it becomes available and report on it in a future issue of the Journal.

Dr. Bauer was referring to Point 4 of the recommendations which he said "is so objectionable we wish to call attention to it immediately." Point 4 reads "Funds collected through the Old Age and Survivors Insurance mechanism be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance group, under a plan which meets federal standards and which does not involve a means test." A means test is a test to determine ability to pay.

Dr. Bauer continued "We wonder if all the commission members

(Continued on page 62)



THE MEDICAL CARE DOLLAR

The above "pie charts" show the proportion of the medical care dollar which physicians receive. Over a 20 year period, the physicians' average share fell 12 per cent and the hospitals' share rose 66 per cent.

Doctors' Incomes Are Increased Little in Relation to Others

Madison, Dec. 28.—While the net income of the average medical practitioner has more than doubled since 1929, the doctor's bill is still one of the least inflated items in the average family budget, according to the AMA Bureau of Medical Economic Research.

Obtaining its figures from the United States Department of Commerce, Survey of Current Business for July, 1952, the bureau quotes cost of medical care in 1951 as 4.3 per cent of an average income. Physicians services accounted for 1.2 of this. Expenditures for tobacco would require 2.3 per cent of the same income, and expense for recreation 5.4.

A down-to-earth comparison between doctors' incomes and industrial incomes is made by Dr. N. E. Clarke, Detroit, in the Journal of the Michigan State Medical Society for June, 1952. He points out that the average weekly pay of an industrial employee in 1893 was $10.93 for a work week of 58.2 hours, while in 1950 he received $60.32 for a 40-hour week. On this basis, the industrial worker's weekly income has increased 550 per cent in 57 years—for eighteen hours less work.

Dr. Clarke is certain that "the average present-day physician's income does not exceed by 550 per cent that earned by doctors sixty years ago."

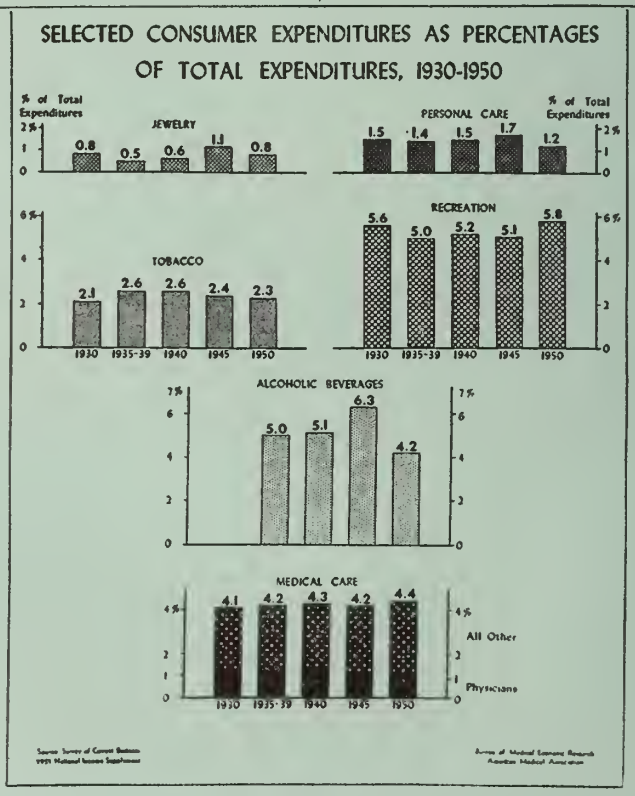
He goes on to explain that the doctor of 1893 charged an average fee of six dollars for a general physical examination. So the industrial worker earning 21.6 an hour was required to work 27.8 hours to pay for this service. Today the general medical practitioner in an industrial city like Detroit charges ten dollars for a general physical, and the specialist will charge fifteen.

He goes on "The present industrial wage earner, paid $1.46 or more an hour, can purchase his medical examination from a general practitioner for 6.2 hours work. He can have it from a specialist for 9.4 hours work.

A survey of physicians' incomes made by Frank G. Dickinson, Ph.D. and Charles E. Bradley, Ph.D. of Chicago for the Bureau of Medical Economic Research reveals a number of interesting facts.

The average net income, before taxes, of 30,000 doctors surveyed was $11,058 a year. These figures broken down into three categories show the general practitioners in the group making an average net of $8,835, those listed as partly specialized making $11,758 and specialists $15,014.

The southwestern and far western doctors claim the highest averages, and the New Englanders the lowest. The central states, including Wisconsin, land financially right in the middle.



HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE BY STATES

Number of People Protected

End of 1951

(000 Omitted)

State	Hospital	Surgical	Medical
EAST NORTH CENTRAL			
Ohio	6,637	4,486	857
Indiana	2,284	2,152	687
Illinois	7,028	4,613	1,342
Michigan	5,195	5,013	2,066
Wisconsin	2,275	1,920	800
Total	23,419	18,184	5,752
TOTAL UNITED STATES	85,991	65,535	27,723

SURVEY CHARTS ARE BORROWED

The charts on this page and the following page were borrowed from the Annual Survey of Accident and Health Coverage in the United States for June, 1952. They appear on pages 20 and 17 respectively. The survey is published by the Health Insurance Council.

The Wisconsin Plan is medical-surgical coverage sold by private insurance carriers with the endorsement of the State Medical Society.

Blue Cross provides only hospitalization coverage.

Private insurance carriers operating in Wisconsin account for the difference between the sum of the medical and hospital operated plans and the total figure.

Benefits, Services Get 78.8 Per Cent of Premium Dollar

Madison, Dec. 20.—Benefits and services to subscribers account for 78.8 percent of the premium dollar paid to voluntary health insurance plans during 1951, according to a bulletin prepared by the Council on Medical Service of the AMA.

Another 7.9 percent of this dollar is used for reserves and miscellaneous expenses to stabilize the various plans and fortify them against any unusually unfavorable claim experience in years to come.

The remaining 13.3 percent goes for the necessary administrative costs—salaries or commissions, rent, postage, printing, advertising and so on.

It is interesting to note that in spite of the relatively short time the majority of voluntary health plans have been in operation, the distribution of premium income approximates that of insurance companies which write group health and accident coverages.

During 1951, a group of 502 capital stock insurance companies surveyed reported a loss ratio of 84.8 percent. 238 Mutual companies reported a loss ratio of 86.5 percent, while 181 prepaid health plans showed a loss ratio of 86.4 percent.

OVER 2,000,000 CARRY PREPAID PLANS IN STATE

Madison, Dec. 15.—Nearly 2,275,000 persons in Wisconsin were enrolled in voluntary health care plans at the end of 1951, according to the latest figures available from the American Medical Association.

According to the AMA's figures, 2,275,000 persons had hospital protection, 1,920,000 had surgical protection and 800,000 had medical protection. It is likely that most of those having surgical-medical protection also had hospital coverage.

These figures do not reflect gains made by the plans during 1952. The following statistics on plans endorsed or operated by Wisconsin physicians or hospitals tell the story up to September 30, 1952:

Plan	Coverage
Wisconsin Physicians Service	267,000
Surgical Care	359,000
Wisconsin Plan (estimate)	300,000
Blue Cross	869,000

Wisconsin Physicians Service is operated by the State Medical Society. Surgical Care is operated by the Medical Society of Milwaukee County. Both are Blue Shield Plans.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

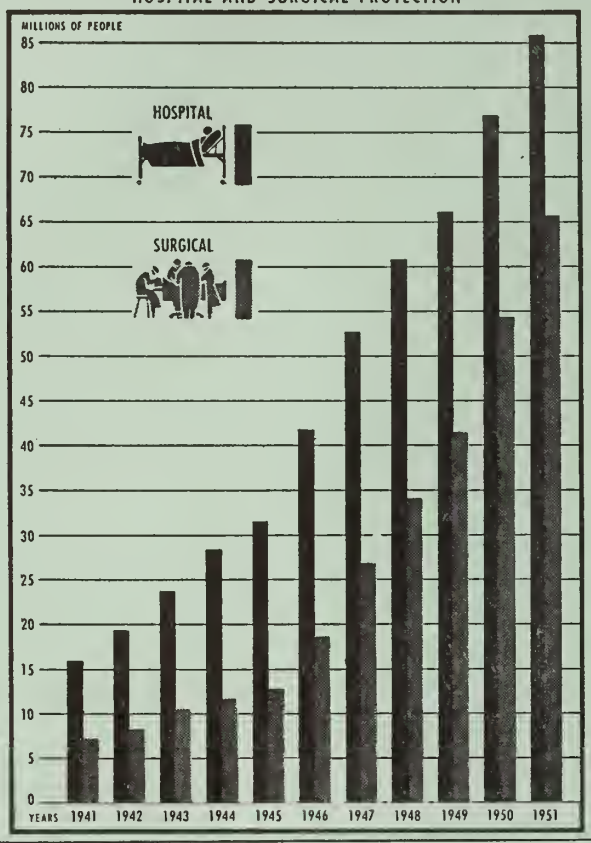
• • •

The Time Insurance Company

813 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

GROWTH IN NUMBER OF PEOPLE COVERED BY HOSPITAL AND SURGICAL PROTECTION



EXPANSION OF PREPAID PLANS IS NATION-WIDE

Madison, Dec. 15.—The dramatic nationwide expansion in voluntary health coverage over the past decade reflects the desire of the American people to help themselves, according to the Survey of Accident and Health Coverage in U.S., published by the Health Insurance Council, New York, in June 1952.

Is Latest Compilation

This publication is the latest accurate compilation of health coverage available at this date.

Hospital expense coverage is the most widespread. At the end of 1951 more than 86,000,000 persons had this protection. Of these, 41,000,000 had their protection through Blue Cross or medical society plans.

Surgical coverage is now held by 66,000,000 persons, a 20 per cent gain over 1950. Medical Society plans and Blue Cross accounted for 24,000,000 of the total.

Medical coverage made great headway during 1951 with the final figure of 28,000,000 up 28 per cent over 1950. Medical society and Blue Cross plans account for 14,000,000 of this enrollment.

Distribution of voluntary coverage is greatest in industrial areas, least in rural areas.

Coal Miners' Medical Care Costs 50 Millions

Washington, December 15.—The largest non-Federal medical and hospital care program in the country today is that of the United Mine Workers, according to the Washington Report on the Medical Sciences.

Administered under UMWA's Welfare and Retirement Fund, it spent approximately $50,000,000 for medical and hospital benefits during the year which ended last June 30. An additional $9,300,000 went for total disability cash payments, part of which went to paraplegics and other disabled miners undergoing medical rehabilitation.

Life Insurance Owned by 79 Per Cent of Midwest Families, Survey Shows

New York, Dec. 12.—While 77 per cent of all families in the U. S. own life insurance today, families in the middle west report 79 per cent ownership, according to the Institute of Life Insurance.

The word "family" as used here stands for "spending unit" or a group of relatives who pool their incomes for major expenses.

The above percentages are shown in the 1952 Survey of Consumer Finances made by the Survey Research Center at the University of Michigan for the Federal Reserve Board.

Income Increases Ownership

Life insurance ownership was observed to be more widespread as income increased, as seen by highest ownership in the east where per capita income is greatest. Families with incomes under $1,000 reported 46 per cent ownership, while 93 per cent of families with incomes in excess of $5,000 are owners of life insurance.

In metropolitan areas, the survey showed, 84 per cent of families possess life insurance. Towns under 2,500 population have 73 per cent coverage, and rural dwellers are lowest with 61 per cent.

Says Prepaid Plans Are Hard on Medical Schools

Washington, Dec. 10.—Dr. A. J. J. Rourke, president of the American Hospital Association, hails the growth of Blue Cross and Blue Shield but says one of its troublesome complications is a resultant dearth of clinical material in teaching hospitals.

Dr. Rourke expressed this opinion at a panel discussion held before the President's Commission on the Health Needs of the Nation in Washington recently.

The AMA Council on Medical Education and Hospitals discussed this problem at the clinical session in Denver last month. It was suggested that the paying public must be educated to the idea that, with the disappearance of the charity ward, they must allow themselves to be used as teaching material in the training of future doctors.

HOSPITAL CONSTRUCTION APPROVED FOR WISCONSIN

Hospital	City	Type	Beds	In Operation
(Approved fiscal year 1947-48)				
Holy Family	New Richmond	Gen.	32	X
Wm. Finney Memorial	Clintonville	Gen.	62	X
Memorial Hospital	Ft. Atkinson	Gen.	72	X
Vernon Memorial	Viroqua	Gen.	31	X
Madison General	Madison	Chr.	128*	X
Kempster Hall	Winnebago	Psy.	248*	X
(Approved fiscal year 1948-49)				
Memorial Hospital	Tomah	Gen.	27	X
Memorial Hospital	Menomonie	Gen.	34*	X
Municipal	Platteville	Gen.	30	X
St. Joseph's	Dodgeville	Gen.	43*	X
Ladd Memorial	Osceola	Gen.	10*	X
Memorial Hospital	Burlington	Gen.	38*	X
(Approved fiscal year 1949-50)				
Memorial Hospital	Darlington	Gen.	36	X
Memorial Hospital	Algoma	Gen.	30	X
St. Benedict	Durand	Gen.	44	X
Municipal	Ripon	Gen.	38*	X
St. Joseph's	Rice Lake	Gen.	54*	X
Memorial Hospital	Waukesha	Gen.	32*	X
Luther	Eau Claire	C&P	51*	X
State Laboratory	Madison	Lab.	-------	X
Victory Memorial	Stanley	Gen.	9*	X
Memorial Hospital	Berlin	Gen.	38*	X
St. Luke's	Milwaukee	Gen.	194	-------
Memorial Hospital	Sheboygan	C&P	63*	X
Columbia	Milwaukee	Psy.	21*	X
(Approved fiscal year 1950-51)				
Memorial Hospital	Boscobel	Gen.	31	-------
St. Joseph's	Hillsboro	Gen.	30	
Community	New London	Gen.	18*	X
(Approved fiscal year 1951-52)				
Vernon Memorial	Viroqua	Gen.	17*	-------
Richland	Richland Center	Gen.	44*	-------
St. Mary's	Rhinelander	Gen.	76*	-------
Lutheran Memorial	Oconomowoc	Gen.	66	-------
Lutheran	La Crosse	C&P	64*	-------
(Approved fiscal year 1952-53)				
Hayward Memorial	Hayward	Gen.	46**	-------
Neillsville	Neillsville	Gen.	45	-------
Spooner Community	Spooner	Gen.	26	-------
Langlade County	Antigo	Gen.	52*	-------
Door County Memorial	Sturgeon Bay	Gen.	53*	-------
Reedsburg Municipal	Reedsburg	Gen.	26*	-------

* After number of beds indicates addition to existing facility. ** Means remodeling of existing facility. The above construction has been approved by the State Board of Health. Most of those hospitals under construction were financed on the basis of one-third federal government funds and two-thirds local funds. Those approved since January 1950 may receive as high as 45% federal funds.

Estimated total cost of this construction is approximately $30,000,000 with local sponsors providing slightly less than $19,000,000 and the federal government furnishing the remainder. Normal bed capacity thus provided totals 1,695 while maximum capacity reaches 1,960.

GUNDERSEN HEAD OF COMMISSION

Chicago, Dec. 6.—Dr. Gunnar Gundersen of La Crosse has become the first chairman of the new Joint Commission on Accreditation of Hospitals.

He assumed his new post at ceremonies held December 6 in Chicago at which the plan which has been carried on for 35 years by the American College of Surgeons was handed over.

Principal speaker on this occasion was Senator Lister B. Hill of Alabama, co-sponsor of the Hill-Burton Act. Dr. Evarts A. Graham, chairman of the Board of Regents of the college turned the program over to Dr. Gundersen.

Proposal for the formation of the joint commission was initiated by the College of Surgeons in recognition that members of other organizations concerned with medical care in hospitals should participate in the establishment and enforcement of hospital standards. From now on, the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association and Canadian Medical Association will share responsibilities of the program.

Sees Future Medicine Divorced from Politics

Washington, December 17.—"Doctors will no longer have to dance to the tune of the Ewing pipers, but can devote their full time and energy to a sound, constructive and unselfish program of better medical care for all people—a program completely divorced from politics."

So spoke Dr. George F. Lull, secretary and general manager of the American Medical Association recently, when asked to comment on AMA's delight at Republican control. It is expected the AMA and the administration will agree on most issues.

Push Petition on Canadian Health Plan

Chicago, Dec. 5.—The Canadian Press from Winnipeg reported that the Cooperative Commonwealth Federation will soon ask Canadians to sign a petition urging the federal government to launch a national health insurance program.

The decision to circulate the petition was announced by M. J. Coldwell, CCF leader, in a speech over the Trans-Canada network of the Canadian Broadcasting System. National health insurance, he said, has been in the Liberal Party's platform since 1919.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

WASHINGTON ADVISES NO YOUNG MDs ARE TO BE DEFERRED FOR RESIDENCY

Washington, Dec. 24.—Local medical advisory committees to draft boards are being advised by Washington to extend no deferment for purposes of residency training to special registrants in Priority III who are in younger age groups.

Have Three Sources

According to Dr. F. L. Weston, chairman of the Wisconsin Advisory Committee, hospitals should attempt to fill their residencies from the following sources:

1. Medical graduates who already have had military service—a group which constitutes almost 80 percent of current interns;
2. Physicians who have been discharged from service, the number of whom now equals the number being called to active duty and
3. Women and other physicians who are not obligated for military service.

Addressing the Association of Military Surgeons recently, Dr. Melvin A. Casberg, chairman of the Armed Forces Medical Policy Council, reaffirmed the necessity of extending the doctor draft but expressed hope that some interns may be passed over into specialty training so as to minimize interference with the output of medical specialists.

FTC QUESTIONS VALUE OF "RUTIN"

Washington, D. C., Dec. 27.—The Federal Trade Commission last week took an extraordinary step in issuing an order branding as worthless a drug frequently prescribed by physicians in hypertension, diabetes and retinitis cases.

According to the Washington Report on the Medical Sciences, the Commission held that Rutin presents no evidence of therapeutic value, not withstanding its continued use by the profession.

"Celparux" is Target

The drug is manufactured by ten or more reputable pharmaceutical houses and has been under respectable clinical use for at least five years or longer. Target of the Trade Commission's order curbing advertising claims was a preparation marketed as "Celparux," each tablet containing 20 milligrams of Rutin and larger parts of parsley, celery and ascorbic acid.

". . . That a substantial number of physicians are prescribing it as a treatment for the very conditions advertised by respondents is . . . immaterial," said the decision. "That a segment of the medical profession may be misleading diabetics is no excuse for respondents likewise doing so."

Court Says Psychiatric Confidences Privileged

Chicago, Dec. 19.—Confidential communications between a psychiatrist and his patient are privileged, according to a decision rendered by Judge Harry M. Fisher of the Circuit Court of Cook county, Chicago.

In the case that resulted in this decision, a patient was receiving psychotherapy at a Chicago hospital. The attorney for the patient's husband requested the court to subpoena the doctor and the hospital's records for testimony in a suit for alienation of affection, in which the husband charged the doctor with stealing his wife's love. The wife had separated from the husband and had instituted suit for divorce.

Both the hospital authorities and the doctor refused to testify before a notary public on the grounds that the communications between patient and psychiatrist were, or should be, privileged. The judge upheld them and denied a motion to compel the hospital to produce its records and the doctor to testify.

Eisenhower, Taft Are Agreed on Commission

Washington, Dec. 20.—President-Elect Eisenhower and Senator Robert Taft, Republican leader in the senate, have agreed that a commission should be set up to study all federal-state relations in the field of aids and grants, including health and welfare problems.

If the idea is approved by Congress, it probably will mean the "freezing" of health and welfare problems at their present levels for the next year while the commission carries on its investigation, according to the AMA Washington office.

Some commission members will be appointed by the new chief executive and the remainder by house and senate leaders. Senator Taft says he expects it to be "predominantly" Republican.

Although the commission would be expected to come up with recommendations covering health, social security and housing questions, Senator Taft said it would also make a searching study of all federal-state financial relationships. He claims to be hopeful that the commission will be able to suggest ways of blocking off or reserving certain areas of taxation for the states, so the states themselves will be able to provide more welfare services and not have to turn to the federal government for help.

Edit Patient's Magazine for MD's Waiting Rooms

St. Petersburg, Fla., Dec. 20.—Doctors in St. Petersburg, Florida are now publishing regularly a magazine for doctors' waiting rooms entitled "The Aesculapian."

The magazine came into being with the doctors' realization that the education of their patients about medical subjects should no longer be left entirely to popular magazines and the newspapers. A sample issue of "The Aesculapian" contains articles on the Republican party health plank, dropsy, overweight, conditioning children for surgery and chemical bread softeners.

Honored for Voluntary Service to Community

New York, December 17.—The Association for the Education of the Mentally Handicapped Child of Milwaukee has been awarded the one thousand dollar Lane Bryant annual award for 1951 in recognition of outstanding volunteer service to their community.

GRAY ANNOUNCES OVERHAULING OF VAST VA AGENCY; WILL SAVE TAX MILLIONS

Three Main Departments Will Report to Chief

Washington, Dec. 27.—VA administrator Carl R. Gray has announced a major overhauling of the vast veterans' agency in a move designed to centralize authority and save taxpayers millions of dollars a year.

One major change is the proposal to streamline the operation into three major departments—a department of medicine and surgery, an insurance department and a veterans' benefit department. Each of these will be headed by a deputy administrator who will be directly responsible to the VA chief.

Departments Streamlined

These new departments will handle activities that previously were divided among so many sections that Gray once had as many as 13 subordinates reporting directly to him.

While favoring many of the proposals made by the management engineering firm that did the survey of the huge veterans set-up, Gray rejects others, such as the suggestion for replacing the agency's 70 regional offices with a smaller number of centers less costly to maintain. Gray maintains the regional offices should be kept as "one-stop service stations for veterans."

Survey Cost $600,000

The survey of the VA agency was conducted by a Chicago firm at a cost of about $600,000 and has been a year and a half in the making. Its findings had been kept secret until Gray's press conference of November 26. Along with the survey recommendations, Gray made many of his own which he said resulted not only from the survey findings but those of the Hoover commission on government reorganization, VA's own staff, veteran's organizations and congressional committees.

Gray's recommendations, if adopted, are expected to save about $10,000,000 a year. The survey firm thought an additional $15,000,000 could be saved through its proposed organizational cuts and changes.

Court to Review Case of Reluctant Private

Washington, Dec. 17.—The U. S. Supreme Court has agreed to review the case of Dr. Stanley J. Orloff, New York psychiatrist, who has been contesting the legality of his induction as a private under P. L. 779 ever since the army took him more than a year ago.

Orloff's contention is that he was inducted under a law intended to provide doctors for the armed services, and since the army is not utilizing him as a doctor, his involuntary detention is in violation of P. L. 779.

The decision of the Supreme Court could have a most important bearing on the shape of future doctor-draft legislation according to the Washington Report on the Medical Sciences. They say that an Orloff victory could result in the government's abandoning its plans to ask congress for enactment of a successor law.

Federal Employee Health Set-Up to Be Evaluated

Washington, Dec. 11.—An interagency committee has been formed to decide what method is to be used to evaluate various health programs for federal employees.

Its long-range objective is to see if the money being spent for preventive health services is paying off, according to T. Roy Reid, committee chairman and personnel director of the agriculture department.

Under the Randolph–Downey Act of 1946, each agency may set up health services for treatment (restricted to minor conditions, emergencies and on-the-job injuries or illnesses), referral to private physicians and promotion of education and preventive health programs. At present each agency must go to Congress to get money for its health set-up, which has led to much red tape.

Mr. Reid stated that eventually the question should arise whether one central agency, such as the U. S. Public Health Service, should be given full control over all federal employee health programs.

WISCONSIN STATE BOARD OF NURSING APPOINTS NEW ADVISORY COMMITTEE

Madison, Dec. 20.—An advisory committee for developing a statewide plan for nursing education has been appointed by the Wisconsin State Board of Nursing. This committee met for the first time November 13th and selected as chairman Matthew Willing of Madison.

Monsignor E. J. Goebel of Milwaukee was chosen vice-chairman and Miss Ellen Evans of Madison General Hospital will be secretary.

Representing the State Medical Society on this committee will be Dr. A. H. Heidner of West Bend and Dr. Burton Waisbren of Milwaukee.

Other committee members include **Mrs. Mary Evans**, Beloit, representing the Wisconsin Hospital Association; **Sister M. Regula**, La Crosse, representing the Wisconsin Conference of Catholic Hospitals; **Sister Mercedes**, Milwaukee, **Miss Margaret Emanuel**, Madison and **Miss Hattie Anderson**, Milwaukee, all of the Wisconsin League of Nursing Education; **Miss Janet Nusinoff**, Mendota and **Miss Gertrude Schmagner**, Ashland, both of the Wisconsin State Nurses Association; **Miss Edithe Turner**, Chippewa Falls, representing the Wisconsin State Organization for Public Health Nursing; **Mrs. R. C. Eby**, Madison; **Richard S. Falk**, Milwaukee, **Ralph Owen**, Eau Claire and **Lewis Brumbaugh**, Ashland.

Mr. Willing and Mr. Brumbaugh represent the field of general education and Monsignor Goebel is of the Wisconsin State Board of Nursing. Miss Evans is of the Wisconsin League of Nursing Education.

Miss Emanuel was appointed chairman of a committee which will do the preliminary planning to determine the advisory committee's objectives, and will report at the next meeting in Madison some time in February. Other members of this sub-committee are Sister Regula and Miss Anderson.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

FOUNDATION WILL ACCEPT GIFTS TO MEMORIAL FUND

Chicago, Dec. 1.—The American Medical Education Foundation is now prepared to accept memorial gifts from those who wish to honor a deceased person in some manner other than the conventional floral tribute.

All such gifts received will be acknowledged to the donors, and notice of receipt will also be sent to the immediate survivors of the deceased. Dr. Casper Epsteen of Chicago, who originally urged the A.M.E.F. to accept such contributions, feels that medical education will benefit by several thousand dollars each year from this source.

Must Identify Contributor

The proper reporting of all contributors will go far in eliminating a problem which has been plaguing the foundation's clerical staff. With increasing frequency checks are being held in the office or returned to state and local offices because of illegible signatures or because, for some other reason, the staff is unable properly to identify the contributor.

Much of this delay can be eliminated if individuals charged with the assembling and forwarding of contributions at the state and local levels will follow these rules:

Follow Three Rules

1. **Don't send loose checks without an accompanying list.**
2. **Be sure your list shows full name and address of donor.**
3. **Retain duplicate copy of each list you forward so that you have a record for tracing lost or questionable contributions.**

Each contribution received at the foundation's office is processed and recorded by an I. B. M. system, but it must be correctly identified so that acknowledgement may be sent. Failure to follow this procedure might result in improper credit and ultimately the loss of a loyal supporter of the foundation's program.

The foundation's total income to date is $782,000 from 5,100 contributors.

TAFT WILL HEAD IMPORTANT GROUP

Washington, Dec. 18. — Senator Robert Taft has announced he plans to assume chairmanship of the important Labor and Public Welfare Committee when the Republicans take over in January.

He says that in the next Congress he will concentrate on social welfare problems rather than labor legislation. In the Republican-controlled eightieth Congress, Senator Taft also headed this committee, but divided his time between social legislation and labor. His labor activity included sponsorship of the Taft–Hartley law.

The Labor and Public Welfare Committee handles a majority of the bills important to medicine, including compulsory health insurance, aid to medical education, aid to local public health departments, drug prescriptions and some veterans bills.

COMPULSORY MEDICINE . . .

(Continued from page 55)

who signed the report understood the full implication of this recommendation. Although the commission does not use the term, this proposal, in effect, recommends national compulsory health insurance.

"We find it extraordinary that this commission should, in its report, recommend a governmental system of paying for medical care which has been rejected repeatedly by the American people, by Congress and by the medical profession.

"In this single recommendation, the commission proposes that funds collected through the Social Security system be used to purchase medical care for beneficiaries, now four and a half million, covered by that system. Under this plan, the federal government, through payroll deductions, would pay directly for the medical care of an ever-increasing segment of our population, and our health services would inevitably be controlled by big government.

"In our cursory study of the report, we have observed numerous false and contradictory conclusions and questionable recommendations which the American Medical Association will comment upon in detail at a later date."

LAUNCH MEDICAL EDUCATION DRIVE

New York, Dec. 15.—The National Fund for Medical Education, with offices in New York, is launching a five million dollar industry-wide solicitation campaign in support of medical education in the United States.

Colby M. Chester, newly-appointed chairman of the fund's Committee of American Industry, will direct a nation-wide organization to mobilize business concerns behind the nation's hard-pressed medical schools. Mr. Chester is honorary chairman of the board of General Foods Corporation.

The National Fund for Medical Education is a lay organization which is working in conjunction with the American Medical Education Foundation which was founded by the AMA two years ago. The A.M.E.F.'s goal for 1953 is included in the five million dollars.

The National Fund's Committee of American Industry, which will spearhead the campaign, will be composed of 100 ranking business leaders from every segment of industry. Their task will be to educate industry as to the critical needs of the medical schools.

The committee contemplates solicitation of 25,000 American business concerns during 1953. Mr. Chester plans to appoint a vice-chairman, an advisory council and division chairmen who will direct the activities of more than 50 industrial committees. E. J. Ade of New York has been appointed fund-raising director for the campaign.

Justice Department Cuts Its Spending

Washington, Dec. 4.—The Justice Department is the only federal department which spent less money last July, August and September than in the same period of 1951, according to a U. S. Chamber of Commerce report.

Total spending for the quarter was $17,800,000,000 or 19 percent above last year. The Chamber notes that the sharpest increases were in "strictly civilian agencies" —Agriculture 60 percent, Labor 60.2 percent, State 53.8, Defense 26.4, Post-office 16.7, Commerce 6 and Treasury 3.4.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN
Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 JANUARY, 1953 Number 1

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

H. K. Tenney—Madison
D. W. Ovitt—Milwaukee
Elwood Mason—Milwaukee
Chalmer Davee—River Falls
G. E. Forkin—Menasha

★

ADVERTISING ADVISORY COMMITTEE

A. L. Tatum—Madison
N. A. Hill—Madison
Harry Beckman—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

What Lies Ahead?

1953 starts out with many good portents for the medical profession. We have weathered the storm of the socialist planners for the past 20 years; and the new administration in Washington is sympathetic to private initiative, including the professions and business, and does not feel that its mission in life is to govern all activities of the American people with a paternalistic touch of a Washington bureaucrat. As we have been on the defensive for 20 years, it might be a good idea to pause and look over the entire situation and re-evaluate it under the changing conditions.

Almost every state medical society in America has gone into the insurance end of medical care with prepaid plans to such an extent that in some instances, one-half of the energy and time of their secretaries and secretarial staffs are devoted to these projects. Our own State Medical Society offices have grown too small for the business, and a move into larger quarters has already been approved by the Council. The Medical Society of Milwaukee County secretarial quarters have also proved inadequate, and plans are afoot to acquire more space. There is no criticism of these moves. They are entirely necessary if we accept the principle that we are and should be in the insurance business and must continue to do a satisfactory job. The only other alternative would be to abandon Blue Shield plans or turn them over to some other agency. The prons and cons of this step have been discussed adequately by the Council of the State Medical Society, and its opinion concurs completely with this writer—that we must continue carrying Blue Shield plans past their birth pains into adolescence in spite of the fact that a more sympathetic administration is in power. Perhaps an invitation to the public to join with us in administering these plans by representation on executive boards should be considered.

The economic side of the practice of medicine has also had to be seriously dealt with in the past 20 years. Public relations committees have developed into a part of every national and local medical organization. Here too we might say "quo vadis." Undeniably, the doctor and his medical associations have, for years, given too little thought to public relations and have now gone all out to rectify these errors. We should by no means lose the gains we have made, but a re-appraisal may be in order. Public relations should be an integral part of our daily activities, not a cloak or shield to be held up when public opinion appears unfavorable.

The scientific part of medicine, or in other words the conquest of disease and the healing of the sick, is still the primary purpose of every doctor and the primary reason for existence of any of the various medical associations. With the prospect that governmental pressures will be put in their proper perspective, all of us can look forward to 1953 as the year we were able to put the majority of our energies and time into healing our fellow man and ameliorating his ills—the sole privilege of our great profession.

Officers of State Boards and Commissions

State Board of Health

Members of the Board

Stephen E. Gavin, M. D., President, Fond du Lac, 1957
Samuel L. Henke, M. D., Vice-President, Eau Claire, 1953
Carl N. Neupert, M. D., Secretary and State Health Officer, Madison, ex officio
William T. Clark, M. D., Janesville, 1956
Carl D. Neidhold, Appleton, 1959
Forrester Raine, M. D., Milwaukee, 1954
Stephen Cahana, M. D., Milwaukee, 1955
Woodruff Smith, M. D., Ladysmith, 1958

Bureaus, Divisions, and Units of State Board of Health

Carl N. Neupert, M. D., State Health Officer
E. H. Jorris, M. D., Assistant State Health Officer

Section on General Administration

E. H. Jorris, M. D., Director

Division of Staff Services
Division of Personnel—Henry Kjentvet, Director
Division of Statistical Services—Vivian B. Holland, Statistician
Division of Fiscal Services—Fred E. Brown, Director
Division of Internal Services—Lenore Brandon, Supervisor
Division of Laboratories—W. D. Stovall, M. D., Director
Bureau of Vital Statistics—Paul Weis, Assistant State Registrar
Division of Dental Education—Francis A. Bull, D. D. S., Supervisor
Division of Health Education—Ralph Kuhli, Director
Division of Hospital and Related Services—Vincent F. Otis, Director
Division of Cosmetology—Kathleen Bower, Supervisor
Division of Barbering—Thomas D. Ritchie, Supervisor
Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor

Section on Preventable Diseases

Milton Feig, M. D., Director
Bureau of Communicable Diseases—Milton Feig, M. D., Director
Division of Tuberculosis Control—Mildred E. Scott, M. D., Director
Division of Venereal Disease Control—A. L. Van Duser, M. D., Director
Division of Cancer Control—A. L. Van Duser, M. D., Director
Division of Heart Disease Control—Mildred E. Scott, M. D., Director

Section on Environmental Sanitation

O. J. Muegge—State Sanitary Engineer
Harvey Wirth—Assistant State Sanitary Engineer
Bureau of Sanitary Engineering—Harvey Wirth, Director
Division of Plumbing—Walter Spencer, Supervisor
Division of Well Drilling—Thomas Calabresa, Supervisor
Division of Rendering and Slaughtering—Arthur F. Rizzi, Supervisor
Division of Water Pollution Control—T. F. Wisniewski, Director
Milk Sanitation—C. K. Luchterhand, Sanitarian

Section on Maternal and Child Health

Amy Louise Hunter, M. D., Director
Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Director
Division of Child Guidance—Eugenia S. Cameron, M. D., Director
Division of Nutrition—Lucile K. Billington, Supervisor

Section on Local Health Administration

Allan Filek, M. D., Director
Bureau of Public Health Nursing—Janet Jennings, R. N., Director
Division of Industrial Hygiene—William L. Lea, Director
Division of Hotels and Restaurants—Harold E. Olsen, Supervisor
Division of Local Health Administration—Allan Filek, M. D., Director

District Health Offices

No. 1—602 Insurance Building, Madison
Health Officer: (Vacancy)
Counties included: Crawford, Richland, Sauk, Columbia, Dane, Green, Lafayette, Iowa and Grant

No. 2—Municipal Building, Elkhorn
Health Officer: (Vacancy)
Counties included: Jefferson, Rock, Waukesha, Walworth, Milwaukee, Kenosha and Racine

No. 3—11 South Main Street, Fond du Lac
Health Officer: James R. Slamer, M. D.
Counties included: Winnebago, Sheboygan, Calumet, Dodge, Manitowoc, Washington, Fond du Lac and Ozaukee

No. 4—City Hall, P. O., Box 251, Sparta

Health Officer: John A. Van Susteren, M. D.

Counties included: La Crosse, Waushara, Green Lake, Monroe, Juneau, Vernon, Adams and Marquette

No. 5—City Hall, P. O. Box 270, Wisconsin Rapids

Health officer: G. G. Shields, M. D.

Counties included: Pepin, Clark, Buffalo, Wood, Trempealeau, Marathon, Jackson and Portage

No. 6—City Hall Annex, Box 383, Green Bay

Health Officer: G. M. Shinners, M. D.

Counties included: Waupaca, Kewaunee, Shawano, Door, Oconto, Brown, Marinette and Outagamie

No. 7—417½ North Bridge Street, Chippewa Falls

Health Officer: R. E. Graber, M. D.

Counties included: Polk, Dunn, Barron, Rusk, Chippewa, Pierce, St. Croix and Eau Claire

No. 8—City Hall, Rhinelander

Health Officer: Frances Cline, M. D.

Counties included: Taylor, Price, Lincoln, Oneida, Forest, Vilas, Florence and Langlade

No. 9—Vaughn Library Building, Ashland

Health Officer: (Vacancy)

Counties included: Douglas, Bayfield, Burnett, Washburn, Ashland, Sawyer and Iron

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies; reorganized by act of 1949 legislature.)

Members of the Board

William H. Studley, M. D., Milwaukee, 1953

Mr. Harold W. Story, vice-chairman, Milwaukee, 1957

Mrs. Harrison L. Garner, Madison, 1953

Mr. Ralph Uihlein, Milwaukee, 1957

W. D. Stovall, M. D., chairman, Madison, 1955

Mrs. Karl Kleinpell, Cassville, 1955

Mr. Leo Jelinske, Shawano, 1955

Mr. Earl M. Hale, Eau Claire, 1953

Mrs. C. R. Beck, secretary, West Allis, 1957

Executive Staff

Mr. John W. Tramburg, Madison, Director

Mr. A. W. Bayley, Madison, Deputy Director

Division of Corrections

Mr. Russell G. Oswald, Madison, Director

Division of Mental Hygiene

Leslie A. Osborn, M. D., Madison, Director

Division of Public Assistance

Mr. George M. Keith, Madison, Director

Division of Business Management

Mr. Wilbur J. Schmidt, Madison, Director

Division for Children and Youth

Mr. Frederick DelliQuadri, Madison, Director

Basic Science Examiners

Prof. Michael F. Guyer, President, University of Wisconsin, 138 North Prospect Avenue, Madison 5, Wisconsin, 1955

Prof. W. H. Barber, Secretary, Ripon College, 621 Ransom Street, Ripon, Wisconsin, 1957

Prof. George G. Town, University of Wisconsin Extension Division, 623 W. State Street, Milwaukee, Wisconsin, 1953

State Board of Medical Examiners

A. F. Rufflo, M. D., 625 Fifty-Seventh Street, Kenosha, 1953

J. W. Smith, M. D., 324 East Wisconsin Avenue, Milwaukee, 1955

E. W. Miller, M. D., 231 West Michigan Street, Milwaukee, 1953

H. H. Christofferson, M. D., Colby, 1953

Alvin G. Koehler, M. D., Secretary, 46 Washington Boulevard, Oshkosh, 1955

J. W. Prentice, M. D., President, 522 West Second Street, Ashland, 1955

E. C. Murphy, D. O., 314 East Grand Avenue, Eau Claire, 1953

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1955

Mr. Harry J. Burczyk, 1953

Mr. R. G. Knutson, 1957

Miss Helen Gill, Secretary

Workmen's Compensation Department

Mr. Harry A. Nelson, Director

Unemployment Compensation Department

Mr. Paul R. Raushenbush, Director

Safety and Sanitation Department

Mr. O. T. Nelson, Director

Woman and Child Labor Department

Maud Swett, Director

State Board of Vocational and Adult Education

E. J. Fransway, Employee member_____Wauwatosa
Emil Waldow, Employee member_____Green Bay
Frank C. Horyza, Employee member_____Superior
Alfred A. Laun, Employer member_____Kiel

Robert L. Pierce, Employer member_____Menomonie
Morton Frost, Employer member_____Kenosha
John Last, Farmer member_____Lake Mills
T. E. Hamilton, Farmer member_____Westfield
Elmer Wilkins, Farmer member_____Platteville
G. E. Watson, ex officio_____Madison
Voyta Wrabetz, ex officio_____Madison
C. L. Greiber, ex officio_____Madison
State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Office

Room 320, State Office Building, Madison

John A. Kubiak_____Chief
J. H. Brown_____Assistant chief
Charles Beardsley
_____Guidance, Training and Placement
Irene M. Dunn_Finances and Mentally Handicapped
A. E. Towne_____Medical Service
Mrs. Mary F. Beyer_____Homecraft
Edward J. Pfeifer_____Psychological Service
Milton Feig, M. D.
_____Medical Administrative Consultant (part time)
Inez F. Belyea_____Medical Social Worker (part time)
Mrs. Thelma Peckham_____Statistician

District Offices

Madison_____Vocational School Building, 211 North Carroll Street, Room 458
C. D. Rejahl, District Supervisor

Milwaukee Vocational School Building, 1015 North Sixth Street, Room 222
L. A. Rumsey, District Supervisor

Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor

Eau Claire_____8 South Farwell Street
Melvin J. Chada, District Supervisor

Local Offices

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor

Racine Vocational School Building
V. C. Bryan, Case Supervisor

Wausau Vocational School Building
L. J. Schultz, Case Supervisor

Superior_____917 Tower Avenue
H. C. Ritzman, Case Supervisor

STATE MEDICAL ADVISORY COMMITTEE

T. J. Howard, M. D._____Milwaukee
G. F. Wakefield, M. D._____West Salem
J. S. Supernaw, M. D._____Madison
R. M. Kurten, M. D._____Racine
H. L. Greene, M. D._____Madison
H. M. Coon, M. D._____Madison
C. N. Neupert, M. D._____Madison
Charles Fidler, M. D._____Milwaukee
H. H. Reese, M. D._____Madison
H. J. Heeb, M. D._____Milwaukee
Harry D. Bouman, M. D._____Madison
R. W. Thompson, D. D. S._____Madison
Miss Marjorie Taylor_____Milwaukee
Miss Janet Jennings_____Madison

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The sixteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 2–5, headquarters at the Municipal Auditorium in New Orleans.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. In addition, the program will include a symposium on "The Value of Newer Drugs," daily demonstrations of medical and surgical procedures in color television, clinicopathologic conferences, medical motion pictures, over 100 technical exhibits, and three round-table luncheons.

The Assembly has planned another interesting postclinical tour to follow the 1953 meeting in New Orleans. On Saturday, March 7, a party composed of doctors and their families will leave New York for Europe on the great new superliner, S. S. United States. The itinerary includes England, France, Switzerland and Italy, and arrangements have been made for medical programs in these countries. The tour ends in Rome and the group will return to New York on March 31 by Pan American World Airways, President Special.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes.

1. File your Wisconsin and federal income tax returns as early in 1953 as possible, *but not later than March 15.*
2. By January 15, 1953, you must pay the final installment of estimated 1952 tax. By this date you must have paid at least 80 per cent of the tax which will be actually due for 1952. If it appears that you will not be within 80 per cent, you may file an amended declaration for 1952 by January 15, 1953, and pay an amount sufficient to bring you within 80 per cent. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.
3. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1952 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1952.
   (3) File fourth quarterly return for 1952 of income and social security tax withheld on wages paid employees on Form 941:
      a. If entire tax not paid by timely depositary receipts.
      b. If less than $100 withheld in each of October, November, and December 1952.
   (4) Pay income and social security taxes withheld on 1952 wages to employees:
      a. If more than $100 withheld in December 1952, and not paid to government depositary earlier in January 1953.
      b. If less than $100 withheld in each of October, November, and December 1952.
4. (1) If instructions contained in paragraphs 3 and 4 of Section 2, preceding, are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31 for the respective preceding calendar quarters.
   (2) If the instructions contained in paragraphs 3 and 4 of Section 2, preceding, are not applicable to your case, in other words, if the total of income and social security taxes withheld on employees' wages exceeded $100 a month and timely deposits for that purpose were made in each of the three preceding months, a quarterly return on Form 941 is due and should be filed on February 10, May 10, August 10, and November 10.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid the month immediately following or by the tenth of the second month after the ending of such calendar quarter, as earlier set out in these instructions.
5. The first quarterly estimate of your own income for 1953 is due on March 15. Further estimates are due by June 15 and September 15 of 1953 and January 15, 1954. On those dates you may also amend your March estimate, if there has been a substantial change in your income. By January 15, 1954, you must have paid at least 80 per cent of the tax which will be actually due for 1953. If it appears that you will not be within 80 per cent, you may file an amended declaration for 1953 by January 15, 1954, and pay an amount sufficient to bring you within 80 per cent. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1953. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license and basic science certificate with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.
3. If you have changed the address or place of residence or professional office or should open an additional office after your annual registration in January, 1953, you must, within 30 days thereafter, notify the Board of Medical Examiners in writing of such change.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 39.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.

3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (2), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness". Section 146.23 (2), statutes.
6. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate. See page 22.

ADOPTION PROCEDURES IN WISCONSIN

Wisconsin physicians are reminded that state statutes have set up definite procedures for adoptions and under no circumstances are physicians, attorneys or other persons permitted to assist with adoption placements except through a licensed Child Welfare Agency, or Public Agency authorized by statute.

PROCEDURES TO FOLLOW

When an unwed mother or married parents have expressed a desire to have a prospective child placed for adoption, acquaint them with state facilities through the Division for Children and Youth (State or District offices) or County Children's Worker to assist them and give information on the availability of licensed agencies giving service in this type of case.

Applicants for adoption of children should be directed to the same agencies.

LICENSED CHILD WELFARE AGENCIES

*The Children's Service Society of Wisconsin, 734 North Jefferson, Milwaukee 2.
Catholic Social Welfare Bureau, 2018 North Oakland Avenue, Milwaukee 2.
Catholic Welfare Agency, 1200—15th Avenue East, Superior.
Catholic Welfare Bureau, 3222 South Avenue, La Crosse.
Catholic Welfare Bureau, 119 East Washington Avenue, Madison 3.
Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.
Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.
The Lutheran Welfare Society, 3126 West Highland Boulevard, Milwaukee 8.
Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

AUTHORIZED PUBLIC AGENCIES

*Milwaukee County Child Welfare Division, County Court House, Milwaukee 3.
*Wisconsin Division for Children and Youth, 315 South Carroll Street, Madison 2.

* Non-denominational.

MATERNITY HOMES

Maternity homes which are licensed in Wisconsin to serve prospective unmarried mothers are:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.
Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.
St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.
St. Mary's Mothers' and Infants' Home (Catholic), 403 South Webster Avenue, Green Bay.
*Summit Hospital, Oconomowoc.

* Non-denominational.

Fees for care vary from $50 to $125, including prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover the cost of service rendered.

The Student Loan Fund

ESTABLISHMENT of the Student Loan Fund of the State Medical Society creates an unusual opportunity for physicians to apply the principles of the Hippocratic Oath by helping youthful aspirants to the profession of medicine achieve their goal. It is reported that "at least half" of the 600 medical students in the two Wisconsin medical schools could use some financial help. About one-third are said to need complete support. With medical education now requiring more and more devotion to studies, and with the yearly cost of such education ranging from $1,200 to $1,750, the Student Loan Fund promises to fulfill a great need.

The Student Loan Fund grew out of a proposal by Dr. H. H. Christofferson, Colby, at his inauguration as president of the State Medical Society in October, 1950. The fund was organized in August, 1951, at the initial meeting of its Board of Trustees. Their goal is the accumulation of a $250,000 fund to provide assistance to needy and deserving medical students.

The fund is a trust administered by a board of seven trustees. Four trustees are the president, president-elect, chairman of the Council and secretary of the State Medical Society who serve as trustees during their terms of office as such officers of the Society. These trustees select three additional trustees, one of whom must be a physician.

Present board members are: J. C. Griffith, M.D., Milwaukee, chairman; the Honorable A. Matt Werner, Sheboygan, vice-chairman; C. H. Crownhart, Madison, secretary-treasurer; Ira R. Sisk, M.D., Madison; R. G. Arveson, M.D., Frederic; A. H. Heidner, M.D., West Bend; and the Honorable Oscar A. Rennebohm, Madison.

The fund will be used to provide assistance in the form of loans, with preference given to students enrolled in the University of Wisconsin Medical School or Marquette University School of Medicine.

Who Is Eligible

Residents of the State of Wisconsin who are presently enrolled, or about to enroll in a class "A" medical school, are considered eligible to apply for a loan. The Board may also grant loans to residents of the state who have received their M.D. degree and are fulfilling the requirements of an internship. Neither premedical students nor residents are eligible for loans at this time.

The applicant must demonstrate to the board's satisfaction that he is in need of financial help, and that such financial help is essential to his medical education.

Applications for student loans must be made directly to the Board of Trustees of the Student Loan Fund.

Loan Limits and Security

A loan may be made in any amount not to exceed $1,000. The applicant may apply as many times as he sees fit, and may obtain more than one loan as long as the total obligation does not exceed $3,000. Loan money will be advanced to the borrower as needed, within the maximum.

Loans are to be repaid within three years of the time the student receives the degree of Doctor of Medicine. If the student severs himself from his medical education prior to receiving the degree, the board may require repayment at an earlier date.

Any interest on the loan is waived until borrower's licensure following the completion of internship or until he has disassociated himself from a medical school voluntarily or otherwise. Where the withdrawal from medical school is temporary, as for example for reasons of health, interest will be suspended during such temporary withdrawal as long as it does not exceed one year. Interest will also be suspended while a borrower is in active military service.

The board is also empowered to suspend interest or extend the maturity date of the loan to fit special circumstances. In no case may interest charges exceed 4 per cent per year. The following interest charges may be applied:

1. Two per cent if paid within one year following licensure.
2. Three per cent if paid during second year following licensure.
3. Four per cent if paid after two years from date of licensure.

Applicants for loans are subject to interview by members of the Board of Trustees. The board must make annual reports to the Council of the State Medical Society and will make other reports at its discretion.

To date, $3,000 has been made available to an applicant or applicants from Marquette University School of Medicine and the same amount to an applicant, or applicants, from the University of Wisconsin Medical School, subject to the following conditions:

1. Applications are to be approved by the deans of the two medical schools.
2. No loan is to be granted for the purpose of consolidating an applicant's pre-existing indebtedness.
3. Any loan without the maximum stated above shall be based on total needs of the applicant for the balance of his educational period, including his year of internship. For example, if an applicant estimates that for the

balance of his period of education he shall require a total of $1,500 but at the rate of $500 a year, then $1,500 shall be earmarked for that applicant and made available to him at the rate of $500 a year.

The Board of Trustees does not feel warranted in making more of the fund available for loans until the size of the fund is increased.

Physicians are urged to make contributions or bequests to the fund. Checks should be made payable to THE STUDENT LOAN FUND, STATE MEDICAL SOCIETY OF WISCONSIN, 704 E. Gorham Street, Madison 3, Wisconsin. Contributions are deductible in computing taxable net income. A contribution blank which may be clipped and filled out by a contributor and attached to his contribution is set forth below.

Any person desiring to leave a portion of his estate for the perpetuation of the fund is urged to designate the bequest according to the following form:

"I hereby give, devise and bequeath to the Student Loan Fund of the State Medical Society of Wisconsin, 704 E. Gorham St., Madison 3, Wisconsin, the sum of _____ dollars to be used for the objects and purposes of the fund."

Every contribution to the fund will be gratefully appreciated. Inquiries or other evidences of interest in the fund may be directed to the State Medical Society or the Board of Trustees at any time.

THE STUDENT LOAN FUND

STATE MEDICAL SOCIETY OF WISCONSIN

704 E. Gorham St.
Madison 3, Wisconsin

I hereby give the sum of $_____ to be used for the objects and purposes of the Student Loan Fund.

Name _____

Address _____

PHYSICIANS ADVISED ON SUBSTITUTION OF SILVER NITRATE

Attention has been directed to the fact that some Wisconsin physicians are reporting on birth certificates the use of penicillin as a substitute for silver nitrate in the prevention of opthalmia neonatorum. While there has been some discussion in professional circles regarding the efficacy of substitutions for silver nitrate, the Committee on Maternal and Child Welfare has expressed the opinion that to date there is insufficient evidence to support such action. Physicians are urged to subscribe to the procedures clearly set forth in the Wisconsin Statutes, which reads:

"146.01 **Infant Blindness:** (1) For the prevention of opthalmia neonatorum, or blindness in the new born babe, the state board of health shall, annually, cause to be prepared and put up in proper containers a one per cent solution of nitrate of silver with instructions for its use. These shall be distributed free to local health officers in quantities sufficient to enable them to, and they shall, deliver one to each physician and midwife. The attending physician or midwife shall use the said solution as directed in said instructions.

* * *

"(3) Any person who violates this section shall be fined not more than one hundred dollars."

On the basis of present procedures set up through the State Board of Health, and the reliable services of the State Laboratory of Hygiene in supplying solutions of correct strength and freshness, it does not appear advisable to the Committee on Maternal and Child Welfare to suggest revision of the Wisconsin statutes at the present time.

Until such time as the wording of the law is changed, physicians are warned to avoid the use of any substitute for silver nitrate in the prevention of opthalmia neonatorum, as violation of the statutes subjects a physician to a possible fine, as indicated, and may subject him to a suit for malpractice.

The position adopted by the committee concurs with that of the American Medical Association as was stated in an editorial which appeared on page 123 of the January 12, 1952, edition of the Journal of the American Medical Association.

Donations and Bequests For Research

IN HIS capacity as a counselor, the physician is often called upon to advise patients who wish to make gifts, donations, or bequests for the purpose of furthering progress in the prevention, control, and treatment of disease. Many physicians themselves wish to contribute to worthy projects in the furtherance of their profession and the medical arts and sciences. With most, this desire is prompted by personal experience or acquaintance with a particular disease or infirmity. Often, their desire to give is accompanied by inadequate knowledge of the means by which their intentions can be carried out.

Almost all charitable, scientific, and educational organizations are empowered by their articles of incorporation or their constitution and by-laws to accept gifts, devises, and bequests of money and property, both real and personal, and to manage and administer such money and property in manners adapted to the proper promotion of the purposes of the donor and the organization. This article is accompanied by a tabulation of the major health and scientific organizations and by the conditions under which they are willing to accept donations or bequests of any kind.

Unless restrictions are placed on their use, donations or bequests made to such an organization will be used for the general furtherance of the objectives and purposes of the organization as outlined in its articles of incorporation.

Persons wishing to assure the use of their donations for specific purposes must describe their intentions in writing at the time the donation is made. It is advisable to communicate directly with the organization to which such a donation is contemplated. The average organization is empowered to accept funds earmarked for specific purposes so long as the purposes fall within the scope of its charter. The board of trustees or a research committee usually evaluates all special requests to determine whether the proposed donation can be used for the purposes intended. Most organizations are very helpful in advising the donor how his contribution may be tailored to the purposes of the organization while carrying out his wishes. Some will make available to contributors a list of approved research projects that await financing.

Direct Donations

When a contribution is made as a gift during the lifetime of the donor, it is customary for the donor to transmit the gift with a letter to the governing body of the organization, such as the board of directors, indicating the manner in which the funds are to be used and such other terms and conditions as might be appropriate. When the contribution is a large one, it is well to discuss the proposal with officials of the organization in advance.

Bequests

If the contribution is to be made by a bequest set forth in a will, it is necessary to specify the title of the organization, and the purpose for which the contribution is to be used. The terms of the bequest may specify that the fund be used for "Research," in which case the organization would determine the particular field of research for which the donation would be used. If the bequest is to be used for research in a specific field or in the causes and cures of a particular disease, the terms should so specify.

The terms of the bequest should also provide whether the entire principal of the bequest, only the income earned on the principal, or both, should be used for the purposes indicated. It is suggested that bequests take the following standard form:

> "I give and bequeath to _____(name)_____, a corporation created under the laws of the State of _____, and located in _____, the sum of ($_____) Dollars, to be used in the furtherance of its objects and purposes."

When the donor wishes to earmark the bequest for particular purposes, the final phrase of the above statement may be reworded to express the intent of the donor.

Memorial Contributions

Every organization accepting contributions offers the opportunity to memorialize the name of the donor or any other designated person in perpetuity. For example, if the bequest is given as a "living memorial" to a certain individual, the terms of the will should specify the name of the fund, such as the "John Doe Fund for Medical Research."

Most organizations employ appropriate procedures for acknowledging contributions according to the wishes of the donor. Families or friends of the person being memorialized may be notified of the establishment of the fund. Donors desiring this type of service are requested to supply the names of those to be notified.

Tax Exemption

Section 72.79 of the Wisconsin Statutes states in effect that all transfers of property (defined as both real and personal) to or for the use of any community chest fund, foundation or association *organized and operated exclusively for religious, charitable, scientific or education purposes* shall be exempt from a gift tax. The 1951 session of the legislature further provided that when other states provide for a similar tax exemption, reciprocity will be granted. It is well to point out, however, that the laws relating to taxation are subject to change at any time and the donor of any substantial gift should consult an attorney for the current law on tax exemptions.

Organization	*Procedure for Making Donation or Bequest*
American Cancer Society 47 Beaver Street, New York 4, New York	*Donations* to the national organization are divided—60 per cent to the state of origin, 25 per cent to the national research program and 15 per cent for the operation of the national office. *Bequests* to the national organization will be used completely by national for purposes outlined in the charter, unless specifically requested for some other purpose.
Wisconsin Division, American Cancer Society 652 East Gorham Street, Madison, Wisconsin	*Donations*—Same as above. *Bequests*, made to the Wisconsin Division, will be used 100 per cent for whatever purposes specified.
American Dental Association 222 East Superior Street, Chicago 11, Illinois	Accepts general and specific donations, particularly for the advancement of dental research.
Wisconsin State Dental Society 1233 Bankers Building, Milwaukee 2, Wisconsin	Same as American Dental Association.
American Diabetes Association 11 West 42nd Street, New York 36, New York	Accepts general or specific donations for dissemination of information, health education and case finding, and research. Please contact Association before making earmarked contributions.
American Hearing Society 817 Fourteenth Street, N.W., Washington 5, D.C.	The objectives of this organization are prevention of deafness, conservation of hearing and rehabilitation of the hard of hearing. It accepts donations for research, education or direct services through local affiliates to be used for general or specific purposes consistent with the above named objectives.
American Heart Association 1775 Broadway, New York 19, New York	Donations and bequests welcome. They are divided 25 per cent to the American Heart Association, Inc. unless the donor specifies differently. Half of the 25 per cent share is earmarked for research, and the remainder for national education and development of state associations. The 75 per cent share is budgeted to research in Wisconsin in the field of diseases of the heart and blood vessels; medical and nursing education; public education in prevention; and community service to cardiac patients.
Wisconsin Heart Association 425 East Wisconsin Avenue, Milwaukee 2, Wisconsin	Same as the American Heart Association.
American Medical Association 535 North Dearborn Street, Chicago 10, Illinois	Will consider donations or bequests made to it for general or specific purposes including research. Acceptance by Board of Trustees depends on conditions incident to the bequest.
State Medical Society of Wisconsin 704 East Gorham Street, Madison, Wisconsin	Members or others who contemplate donations or bequests to the State Medical Society for general or specific purposes are requested to contact the Secretary.
American Medical Education Foundation 535 North Dearborn Street, Chicago 10, Illinois	Contributions or bequests made to this AMA-sponsored Foundation are entirely devoted to support of medical education. Any gift may be earmarked for any one of the 79 approved medical schools in the nation.
American National Red Cross 17 & "D" Street, N.W., Washington, D.C.	The corporation may receive gifts, bequests, devises, legacies, and donations for such purposes as are within the general scope of its corporate purposes and powers, and upon such acceptance shall expend and administer such contributions for the purposes specified. Unless the local chapter is specified as the beneficiary, funds derived from gifts made by will, trust, or similar instrument, go to the national organization.
American Pharmaceutical Association 2215 Constitution Avenue, Washington 7, D.C.	Accepts donations or bequests for general or specific use. Suggest query before making earmarked contribution.
Wisconsin Pharmaceutical Association 161 W. Wisconsin Avenue, Milwaukee 3, Wisconsin	Same as American Pharmaceutical Association.
American Public Health Association 1790 Broadway, New York 19, New York	Funds earmarked for specific research accepted if the proposal is within the program and objectives of the Association. Communications are welcome.

Organization	*Procedure for Making Donation or Bequest*
American Social Hygiene Association 1790 Broadway, New York 19, New York	Accepts any kind of donation or bequest, including those for such specific research in the field of venereal disease control as it is "in a position to carry out with competence."
Arthritis and Rheumatism Foundation 535 Fifth Avenue, New York 17, New York	Accepts donations and bequests for general or specific research in the rheumatic diseases; improvement of community treatment facilities, and other stated objectives for control of arthritis and rheumatism. Earmarked donations and bequests are acceptable if designated purposes are in line with Foundation policies and program. With earmarked donation, send explanatory letter. For bequest, use a standard statement.
Wisconsin Arthritis and Rheumatism Foundation 208 East Wisconsin Avenue, Milwaukee, Wisconsin	Accepts general or specific donations. Contact association before making earmarked contributions.
Marquette University School of Dentistry 604 North 16th Street, Milwaukee, Wisconsin	Accepts donations for dental education and research. If a specific type of research is requested under a bequest, the Dental School will reserve the right to decide whether the fund and the research under it is appropriate before accepting the fund. Donations are to be made to the "Marquette University School of Dentistry."
Marquette University School of Medicine 561 North Fifteenth Street, Milwaukee 3, Wisconsin	Accepts donations for medical education and research. Donations are to be made to the "Marquette University School of Medicine."
National Association for Mental Health, Inc. 1790 Broadway, New York 19, New York	Accepts any funds for its program to promote the cause of mental health. Any contribution earmarked for specific research is subject to the approval of the Professional Committee of the National Association.
Wisconsin Association for Mental Health 405 East Grand Avenue, Beloit, Wisconsin	Accepts funds for the promotion and conservation of mental health, including those earmarked for specific research and educational activities. All program activities subject to approval of Board of Directors.
National Epilepsy League, Inc. 130 North Wells Street, Chicago 6, Illinois	Accepts contributions for specific research in the causes and treatment of epilepsy. Funds may be earmarked for educational and clinic use as well as for pure and applied research. Donations may be made to national organization or its affiliated state groups. Request use of standard statement on bequests.
National Foundation for Infantile Paralysis 120 Broadway, New York 5, New York	Accepts any contributions or bequests. If the contribution is made through a county chapter, one half will be used for local service, the other half will be sent to the National Foundation for research. If the donor wishes the entire donation to be used for research, the donation must be accompanied by a statement to that effect.
National Fund for Medical Education 475 Fifth Avenue, New York 17, New York	Accepts contributions or bequests to be used in support of medical education. Acts as distributing agency for all funds collected for aid to medical schools, including contributions to the American Medical Education Foundation.
National Multiple Sclerosis Society 270 Park Avenue, Suite 7G, New York 17, New York	Accepts any contributions or bequests for use in program of combating Multiple Sclerosis. *Earmarked Gifts* are used as indicated by the donor, providing the project meets with the approval of the Medical Advisory Board and the Board of Directors. *Unearmarked Gifts* will be used for general program and divided with the local chapter on a 60–40 basis, 60 per cent for the chapter and 40 per cent for the National Society. Interested donors may write the Society for information concerning the current research program and the approved proposed projects.

Organization	*Procedure for Making Donation or Bequest*
National Research Council 2101 Constitution Avenue, Washington 25, D.C.	Accepts donations for fundamental and clinical research in a score of fields in the medical sciences. Donations may be earmarked for a particular project. Write Business Manager specifying amount that is desired to be contributed and purposes for which a contribution is to be made.
National Safety Council 425 North Michigan Avenue, Chicago 11, Illinois	Accepts donations or bequests for general use or specific research and program projects in harmony with objective of reducing deaths and injuries due to accidents.
National Society for Crippled Children and Adults 11 South LaSalle Street, Chicago, Illinois	Accepts donations or bequests for education, direct service, or research. Will use funds for these three purposes unless otherwise specified. Donor may specify that fund be used for specific purposes by the Wisconsin Association for the Disabled.
Wisconsin Association for the Disabled 119 East Washington Avenue, Madison 3, Wisconsin	Accepts donations for research, education, and direct services for crippled children and adults. Requests donor to contact Association when wishing to designate funds for a particular purpose.
National Society for the Prevention of Blindness 1790 Broadway, New York 19, New York	Accepts funds or donations for specific research when requested. Unrestricted donations may be used for medical research, preventive services, and education of lay and professional persons. In making bequests, use of standard statement is requested.
National Tuberculosis Association 1790 Broadway, New York 19, New York	Accepts any donations or bequests, but prefers they be given for general research purposes.
Wisconsin Anti-Tuberculosis Association 1018 N. Jefferson Street, Milwaukee 2, Wisconsin	Accepts donations and bequests for general or specific use in furthering the purposes of the association in the fields of education and demonstration for the eradication of tuberculosis and the rehabilitation of tuberculous persons.
Sister Elizabeth Kenny Foundation 2400 Foshay Tower, Minneapolis 2, Minnesota	Accepts contributions or bequests to finance varied program in field of polio. Funds contributed finance clinical research; provide scholarships to trained registered nurses and physical therapists to become Kenny Therapists; provide the Kenny treatment at no charge to polio victims; finance treatment centers; conduct medical seminars; and provide public information relative to the Kenny concept and treatment of polio.
Student Loan Fund of the State Medical Society 704 East Gorham Street, Madison, Wisconsin	Accepts donations or bequests to assist worthy and deserving medical students in attaining their professional education. Funds will be used at the direction of the Board of Trustees. Address donations to the Board.
United Cerebral Palsy Associations, Inc. 50 West 57th Street, New York 19, New York	Accepts donations for general or specific use in the care, treatment, and rehabilitation of the cerebral palsied and for research in cerebral palsy. Local United Cerebral Palsy affiliates exist in many communities and accept donations under the same conditions.
University of Wisconsin Medical School 418 North Randall Street, Madison 6, Wisconsin	Accepts funds or donations for general or specific research. Assures exact stewardship for any research program in areas where it is qualified to serve. Bequests should be made in standard statement to "The Regents of the University of Wisconsin" or "The University of Wisconsin Medical School" and specify the terms under which the bequest should be used.
Wisconsin Alumni Research Foundation P.O. Box 2059, Madison 1, Wisconsin	Donated funds are usually incorporated in the general investment portfolio of the Foundation. All grants for research are made through the University of Wisconsin Research Committee. Distribution of yearly grants is at the discretion of this committee except for earmarked funds which carry with them specific directives when allocated to the committee. Address donations to the Board of Trustees.

Medical Partnerships

Introduction

WHEN two or more physicians decide to be associated with one another, such association takes one of three forms. Under one form, one of the physicians, usually the older, employs one or more other physicians on a salary, or a combined salary and bonus basis. A second form of association is one under which two or more physicians share the reception room and laboratory facilities, as well as clerical staffs, on an agreed basis, but each retains the full earnings of his professional practice. The third, and most intimate form of professional association, is the partnership. Under such an arrangement, two or more physicians agree to share the profits and losses and the other ups and downs of their pooled professional efforts.

Practice in the form of a corporation has been excluded from consideration here because of the well established legal principle that a corporation cannot practice medicine. Accordingly, a corporate organization in the medical field usually is limited to the ownership of land, building, and equipment which may be leased or otherwise made available to two or more physicians. Those complications represent a separate subject which does not properly fall within the scope of this article.

Nature of Partnership; Some Disadvantages

A partnership is one of the closest forms of personal and legal association which exists. On the legal side, inasmuch as each partner is held by law to be an agent of the partnership, he may bind the partnership by his actions, which is another way of saying that he may bind all other partners. That is especially true of a state like Wisconsin, which does not regard the partnership as possessing legal entity or personality, such as characterizes a corporation. The law of this state regards a partnership as nothing more than an aggregation of two or more persons. Such action by one partner may be nothing more than the decision to subscribe to a magazine or to purchase a new piece of equipment. In another situation it may also involve his partners in alleged liability for negligence in the treatment of a patient.

Further, the partnership assets are subject to the rights of the creditors of each partner for obligations incurred by that partner in the conduct of partnership's activities. Such creditors, having established their rights, may proceed against the full partnership assets should that be necessary to satisfy such rights.

Clearly, there are substantial professional personal and financial risks implicit in the partnership relationship.

Some Advantages of a Partnership

One of the principal advantages of a partnership is that it permits the pooling of professional skills, of separate backgrounds, and of the power of different types of men to attract patients. In the practical financial aspect, a partnership permits the pooling of capital. It also serves as a cushion against losses to have one or more persons share those losses. Where all but the owner of a practice are on a salary basis, such owner has to carry losses alone.

A further marked advantage of a partnership arrangement is the relatively greater stability of professional practice which this type of association makes possible. Not only is consultation likely to be freer while all partners are there, but there is greater likelihood of continuity when a partner is absent for any cause, or when he retires or dies. This factor of continuity is advantageous alike to the patient and physician. A partnership can build its practice at certain standards with greater assurance than is probably possible in other types of association, that such standards will be continued during the absence or following the withdrawal or death of one or more partners.

On the economic side, disposition of a practice can be more flexibly arranged through a partnership than through other means. The conclusion seems warranted that the reasonably assured advantages of a partnership substantially outweigh its potential disadvantages.

Establishment of a Partnership

A partnership may in fact exist by consent and understanding between the partners, even though the fact is not known to the general public. It may also exist by oral understanding, or by operation of law, even where there is no formal agreement. The first arrangement might have possible ethical considerations. The second type is clearly imprudent on tax and other financial grounds. Every partnership between professional men for the open practice of their profession on an association basis should be openly and publicly declared. Further, every such association should, for the protection of the parties during life, and for the protection of their estates and families on death, be formalized in a written contract.

Advantages of a Written Partnership Agreement

It is entirely possible for two reasonable individuals who are dealing with each other on a verbal basis to misunderstand each other. No contract can be written which will cover all situations, or

remove all such possibilities. Areas of potential misunderstanding can be greatly reduced, however, when the intention of the parties on basic matters is put in writing. Such questions as name and the right of its continuing use; the inclusion or exclusion of such intangible factors as good will; the valuation of tangible assets and of accounts receivable, either of which may vary substantially from those shown on the partnership books; the share of each partner in the capital of the partnership; the share of each partner in the gains or losses of the partnership, which again, may vary substantially from his capital investment, all these, and many other points may be covered, and are ordinarily settled by a competently drafted partnership agreement.

Termination of Partnership

Ordinarily, a partnership between physicians is dissolved on the withdrawal or death of any of the partners. A partnership agreement may provide, however, for the continuation of a partnership in either contingency. Thus, the retired partner may continue to enjoy the fruits of his efforts on at least a limited basis during the period required for collecting his accounts and winding up his interest.

In like manner, the widow and children of a deceased partner may, through contract made while the physician was alive, avoid the disadvantage of a forced liquidation. This ordinarily will permit a greater total payment to the retired physician, or to the heirs of a deceased physician, than is possible from an immediate sale or other liquidation of his interest. It also permits a substantial tax saving to the surviving partners under the present provisions of the federal income tax law.

The tax advantage above mentioned has a rather technical basis which can be summarized with substantial accuracy as follows: Where a partnership agreement makes no provision for the sale of the interest of a retired or deceased partner, the purchase of such interest by the remaining partners is not deductible by them for income tax purposes, but has to be capitalized. Only those portions of such capital investment as are depreciable can be written off during the useful life of such assets.

On the other hand, where an inactive or deceased partner has a continuing participation in the net income of a partnership for an agreed period, such income is reportable and taxable as to him or his heirs as ordinary income, rather than as capital gain or loss. All such payments are *deductible* from the net partnership income of the remaining active partners. Generally speaking, the inactive partner or his heirs suffer no substantial tax disadvantage under such an arrangement; whereas, the living partners enjoy a substantial tax advantage by reason of which they can pay more for such interest than would otherwise be the case.

Basic Provisions of a Partnership Agreement

Following is a list of basic provisions which should be carefully worked out and inserted in a partnership agreement. Accompanying them are brief comments either to indicate the importance of the provision, or advice as to its phrasing.

1. *Name and Purpose.*—The name should be chosen carefully, and will frequently bear the names of two or three partners (seldom more), or of the community. If the name of one or more partners is used to designate the professional firm, the contract should provide whether the right to continued use of such name is to survive the retirement or death of such partner.

2. *Location.*—The locality in which the partnership proposes to practice should be set out specifically. If the partners conclude that they wish to insert into the contract a covenant limiting the right of a withdrawing partner to engage in practice within a particular area for a particular time, this should be done carefully in the body of the agreement. It is also necessary that the area limited and the time provided in such case be reasonable under all the circumstances.

3. *Duties of Partners.*—The agreement should set out with care whether the partners are to give full or part time to the affairs of the partnership, and to provide any limitations on possibly conflicting other professional activities, or on non-professional activities.

4. *Managing Partner.*—It is frequently advisable to designate a managing partner. This centralizes authority for purchasing, for making financial decisions, and for establishing essential supervision over nursing, technical and clerical staffs. It may be desirable to rotate the management so as to give all partners such experience over a period of time.

5. *Initial Valuation of Partnership Assets.*—It is important that the agreement designate carefully just what assets are included in the initial capitalization of the partnership. Such tangible assets as professional library, equipment, and cars, are relatively easy to evaluate. Such intangible assets as outstanding accounts and notes receivable are likewise fairly easy to evaluate. The difficulty arises when one seeks to place a monetary valuation on such intangible assets as an established professional name, the right to continue the use of that name, the value of an established practice, the value of an advantageous long-term lease, and the like.

6. *Capital Investment.*—The agreement should set out carefully the percentage of interest of each partner and the amount of capital to be paid by him; also which interests have been paid for, or partially so. Any partnership interest not wholly paid for should be the subject of carefully worked out business arrangements. The most common of these is the giving of a note without interest, or at a low rate, to be paid the lending partner or partners by the borrowing partner out of the latter's annual share of net partnership profits.

7. *Sharing and Definition of Expenses.*—While it might seem too obvious to insert, it has been found good practice for the contract to make it clear that all partners agree that expenses shall have the first claim on partnership gross earnings, also what items are to constitute such expenses.

8. *Sharing of Profits or Losses.*—The share of each partner in the net profits and losses of the firm should also be set out with care. This may, but need not be the same percentage as the interest of each partner in the capital structure. A younger physician, for example, might have the same financial investment in a medical partnership as an older partner, but be less productive of professional income. Ordinarily, the younger partner would not have the same drawing power. Such differences can be reflected by agreement as to the extent of participation of each partner in the net profits or losses of the firm. As a matter of law, the sharing of profits or losses is perhaps the most fundamental single test in determining whether a given association is a partnership or something else.

9. *Partnership Drawings.*—The actual financial outcome of a partnership year obviously cannot be determined until the year has ended and the books have been closed. The usual practice is to establish drawings for each partner which resemble salaries, but which are *not* deductible for income tax purposes as salaries are. The reason for the difference in treatment is that salary is an expense, but it is recognizable only where an employer–employee relationship exists. Partners are considered in tax law as associated self-employed persons who are not allowed to deduct as expenses what they earn and pay themselves. It is a prudent practice to establish aggregate drawings at not over 85 to 90 per cent of estimated net income. This allows the partnership to maintain a desirable working capital and to establish some savings for year end distribution or for periods when one or more partners is ill.

10. *Distributed vs. Distributable Shares.*—The problem in this field may be best illustrated by example. Assume that the share of Doctor X in the net cash income of a medical partnership for a particular year was $20,000. Assume during that year he had drawn $1,500 a month, or a total of $18,000. The latter figure of $18,000 is the *distributed* share, namely, what he actually got. The figure of $20,000 was his *distributive* share, or the one to which he was entitled on a bookkeeping distribution of the net earnings when the books for the year were closed.

Doctor X can draw or retain in the firm the $2,000 as soon as it has been determined that he is entitled to that extra amount as the balance of his share of profits for the year. He must, in any event, report that higher figure for *both* federal and state income tax purposes, whether he draws it out of the firm or leaves it there.

Conversely, if Doctor Y of the same firm drew $1,000 a month during the year, or a total of $12,000, and his *distributive* or earned share was found at the end of the year to be only $10,000, he would owe the firm the sum of $2,000. This is the excess of the *distributed* or estimated advance payment to him over what was ultimately determined to be his true or *distributive* share. He would report for income tax purposes not the $12,000 which he drew through erroneous estimate, but the $10,000 to which he was entitled by the terms of the partnership contract.

This point should be covered in the agreement.

11. *Vacation and Postgraduate Study.*—It is advisable to establish by formula the period of vacation of each partner. It is common to do this on a basis of the length of time a partner has been a member of a particular firm, or a predecessor firm in the same community. Agreed vacations are known to vary from a minimum of two weeks to as much as three months in this state.

In like manner, it may be advisable to provide by contract for the allowance of time needed for postgraduate studies, or for participation in affairs of professional medical organizations, should it be anticipated that one or more partners will desire or require a substantial amount of time for such purposes.

12. *Illness of Partner.*—On this important subject, four points may be emphasized. The first is that a medical partnership is generally collecting past due accounts. Thus, the financial impact caused by the sustained illness of a partner is not felt at once. Second, there is a difference between partial and total incapacity. Third, there is a great difference between temporary and permanent disability, whether partial or total. It is well for a partnership agreement to provide the financial arrangements which are to control during the illness of a partner. Any such arrangements should take any of the three above factors into account.

A fourth factor is the amount of disability or time loss insurance which the partnership may carry for each of its members, or which the members may carry as items of personal expense. The premiums of such policies are not deductible for income tax purposes; neither are payments to physicians under such policies includable in gross income.

Following are typical arrangements made to cover the illness of a physician partner:

(*a*) If the illness or incapacity is partial, and does not extend beyond six months, no reduction is made in drawings.

(*b*) If such partial incapacity continues beyond six months, an adjustment in such partner's financial participation in the firm is to be negotiated which will recognize the extent to which he can practice his profession.

(*c*) If the illness or incapacity is total, maintain established drawings of such partner in full up to six month maximum.

(*d*) If such total incapacity continues beyond six months, reduce such financial participation by degrees, so that after 18 months, for example, the remaining partners could dissolve the firm, or make other arrangements suitable to them. Established

drawings of such a partner might also be reduced after six months by the amount of his payments under disability or time loss insurance, up to an agreed figure or percentage.

13. *Withdrawal, Retirement, or Death of a Partner.*—Of all the problems faced by a partnership, there are probably none which are more difficult to evaluate and to solve by contract than the related problems of withdrawal, retirement, or death. As used in this connection, "withdrawal" means the optional leaving of a partnership, irrespective of cause other than health. "Retirement" is limited to the leaving of a partnership on grounds of health.

On consideration, it would seem rather evident that where a partner is withdrawing from a firm because the other partners wish it or because he desires to practice elsewhere, there are elements of dealing at arm's length and of individual judgment and volition which are lacking in the other two situations. Further, there is a far greater element of individual judgment and of negotiation possible upon retirement for health reasons than there is with an estate or heirs following death.

Some medical partnerships are beginning to reflect some of the above factors in the financial settlements made where a partner leaves a firm. Ordinarily, the settlement will be smallest where a partned *withdraws;* it will be more generous where a partner *retires* for reasons of health; it will be most generous where a partner *dies* without having withdrawn or retired. The legal and tax considerations of such arrangements call for careful draftsmanship if the wishes of a partner and the maximum advantages of such arrangements are to be assured.

14. *Insurance.*—The partnership agreement should consider at least two types of insurance. The first is what insurance is to be carried by individual partners. This would ordinarily include individual malpractice and car insurance.The minimum limits of such policies should be set out in the agreement, or left in the discretion of the managing partner. It may also include minimum amounts of disability or time loss insurance.

The second type of insurance is that to be carried by the partnership, generally as an expense. This would include public liability on the premises of the partnership; partnership malpractice insurance covering the potential liability of all partners for the professional acts of any one of them; workmen's compensation and employer's liability; fire and extended coverage on equipment and library of the partnership; rental or similar insurance to cover special expenses in connection with loss due to fire or other casualty, non-ownership automobile and hired car insurance; comprehensive coverage on the cash and securities of the partnership, including wrongful loss or mysterious disappearance.

If the partnership concludes to carry disability or time loss insurance on its partners, this can be handled by the partnership as a matter of convenience, but it should be charged to the individual drawing accounts of the partners, since such premiums are not deductible for income tax purposes. The same holds true for the same reason, among others, of life insurance, which is discussed in the next paragraph.

A third class of coverage, although not treated in the partnership agreement, is life insurance, which the partners carry on the lives of each other. Thus, if Doctors X, Y, and Z were partners, and each of them was insurable, it is a common practice to provide by a *separate* contract, wholly independent of the partnership agreement that Doctors Y and Z will insure the life of Doctor X and pay the premium thereof in agreed ratios, and that Doctors X and Z will do the same for Y, and Doctors X and Y will do the same for Doctor Z.

The above arrangement can also be handled through a trust agreement, although this is needlessly cumbersome and costly unless a large insurance program is involved. While premiums on such policies are not deductible as expense, the receipt of insurance proceeds by the surviving doctors is not taxable as income. Neither are such insurance proceeds taxable to the estate of the deceased doctor where he did not own or control the policy.

15. *Professional Records.*—It is well for a partnership agreement to provide what disposition is to be made of case histories and other professional records in the event of retirement, withdrawal or death of a partner, or dissolution of the partnership.

16. *Dissolution.*—If an agreement is silent as to dissolution of a partnership, the Wisconsin statutes control. Where special arrangements are preferred by partners, it is believed desirable that this subject be spelled out in the partnership agreement.

Conclusion

Few personal or professional decisions are more important in the life of a practicing physician than that of entering into a partnership. It is necessarily an intimate relation at professional, financial, and personal levels. It should not be entered into lightly, or with undue haste. Each partner should know the professional qualifications, the character, and the habits of the other. Personal congeniality is highly desirable because of the inevitable closeness of the working arrangement.

Once the above considerations have been duly weighed, the matter should be carefully discussed with an attorney. If the latter should not be familiar with certain of the ethical and other considerations which distinguish medical practice and which should carry over into medical partnerships, the physicians should inform their attorney on such points. It is also believed prudent, in terms of time saving and tax saving, to have partnership books established and periodically audited by a certified public accountant.

Partnerships which are entered into with the care above indicated and recommended should have a correspondingly greater likelihood of successful operation and survival.

Physicians and Child Placement

THE Attorney General, in an opinion to the Wisconsin Department of Public Welfare, concluded that a physician who assists in, or arranges for, the placement of a child by its parent or guardian in the home of a stranger, violates the Wisconsin Statutes. Illustrative cases are set forth and considered in the Opinion, and indicate the extent to which a physician may properly act in this field. The Attorney General's opinion may be found at 37 O.A.G. 403.

Illustrative Cases

"A. The physician who confined Miss A, an unmarried mother, learned that she had expressed a wish to place her child for adoption. He therefore informed Mr. and Mrs. Y, who were patients of his, that he knew of a child that would be available for adoption. He gave the name of the adoptive parents to the mother. They made arrangements to transfer the child to them upon discharge from the hospital. The adoptive parents sent a relative to meet the mother outside the hospital and the relative transported the child alone to the prospective adoptive home.

"B. The physician who confined Miss B, an unmarried mother, learned that she had expressed a desire to place her child for adoption. The physician told the mother that he knew a desirable adoptive home. He communicated with the proposed adoptive family, telling them about the child and suggesting that they employ an attorney. Subsequently the attorney visited the mother and obtained the mother's consent. Upon discharge from the hospital the mother and child were met by the adoptive parents who took the child to their home.

"C. A nurse employed on the staff of the hospital where Miss C was confined, learned that Miss C wanted to make an adoptive placement of her child. The nurse talked to Miss C and informed her that she knew a family who would be interested in adopting her child. She also informed the family about the child and suggested that they come to the hospital to see the baby and to talk with the mother.

"D. Miss D informed her physician that she wished to place her child for adoption. The physician informed her that he knew families who wished to adopt and offered to take the baby and place it in an adoptive home. Miss D consented to this and the physician took the baby to the adoptive home.

"E. Miss E informed her physician that she wished to place her child for adoption. The physician told Miss E that he knew of a good home for the child. Miss E stated that because of her confidence in the physician she would place the child with anyone he recommended. The physician then informed the prospective adoptive parents and suggested that they employ an attorney. They conferred with an attorney, informing him that they had received information from the physician about a child that was available for adoption. The attorney conferred with the mother and arranged through the physician's office to personally take the baby upon the mother's discharge from the hospital. Thereafter, the attorney personally took the baby from the mother and delivered it to the adoptive parents. The attorney justified his actions on the grounds that he deemed it a desirable service to his client to prevent the mother from learning the names of his clients and to prevent the clients from learning the name of the mother. It was the position of the attorney that the mother had made the placement and that he had nothing to do with the actual placement as distinguished from the adoptive proceedings. You inquire whether the attorney violates section 48.37 (1) in that he "assists" in the placement.

"In case A it is our opinion that on the narrow fact situation presented no successful prosecution could be maintained. While it could be argued that one who gives information gratuitously to the parties performs a material act of 'assistance,' it is our view that unless more could be shown it would be impossible to obtain a conviction. If the physician, in addition to informing the prospective adoptive parents of the existence of the child, actively promoted the placement, there would be a clear violation. But just passing on the information is insufficient in our judgment to warrant a prosecution. The doctor could always say that nothing he did prevented the parties from using proper channels in obtaining the placement. Nor was the act of the relatives in taking possession of the child for the adoptive parents, after the arrangements had been made, sufficient in our judgment to warrant prosecution.

"In case B it is also our view that the physician should not be prosecuted for merely giving the information, particularly since he suggested employment of an attorney. The attorney, according to the facts stated, merely performed a legal service in obtaining the mother's consent and did not 'assist' in or 'arrange' for the placement in the sense meant by the statute.

"It should be repeated, however, that in both cases A and B if additional facts were shown there might well be grounds for prosecution.

"In case C it does not appear that any placement was made, but the nurse informed the mother that she knew of a family who would be interested in adopting the child, and also told the family about the child and suggested that they come to the hospital. Her conduct was not such as to violate section 48.45 (1) because it does not go so far as

to constitute a representation that she was *able to dispose of* the child.

"Case D is a clear violation of section 48.37 (1) since the physician did everything necessary to the placing of the child.

"In case E the physician knew that his recommendation would be followed because of the mother's confidence in him. It seems that he did more here than in either case A or case B. It would appear that he *recommended* the prospective foster home. If so he 'assisted' the mother in placing the child by making such recommendation and by putting the parties in touch with each other, notwithstanding his suggestion that an attorney be employed. The attorney also clearly 'assisted' in and 'arranged' the placement. His attemped justification is not valid, since he did more than perform a legal service. His theory would result in exempting attorneys altogether from the application of sec. 48.37 (1). Such exemption was not put in the statute by the legislature and cannot be read into it by implication."

The Attorney General, in the same opinion, discusses the reasons why the state itself, or through its licensed private agencies, has undertaken to perform the function of child placement.

"Experience has shown that so-called 'irregular' placements do immeasurable harm in many respects. They have come to be known popularly as constituting a 'black market' in babies. Even the most well-intentioned persons usually lack the necessary training and are unable or unwilling to make the necessary investigation to determine whether a particular placement is in the best interests of the child. Sometimes, not always, pecuniary matters are permitted to outweigh considerations of the child's welfare, as when the prospective foster parents agree to pay the lying-in expenses. But even in cases where that element is lacking, a great deal of mischief may result. The prospective foster parents may find later that the child has physical or mental defects or conversely the foster home may not be suited for the child. It may happen, too, that proper legal steps to terminate the rights of the natural parent or parents or to obtain their consent to an adoption have not been taken and later on the natural parent or parents cannot be located, or even in some cases identified."

Statutes on Child Placement

"**48.37 Licenses; Records; Reports.** (1) No person other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed Child Welfare Agency.

"**48.40 Violations.** (1) Whenever the State Department of Public Welfare shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a Child Welfare Agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it either may issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of Section 48.41.

"**48.41 Penalties.** (1) Any person who shall act as a Child Welfare Agency without a license as provided in this chapter or who shall violate any of the provisions of the Statutes relating to the organization, conduct and operations of Child Welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the County Jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation."

If questions arise regarding particular cases, it is suggested that the physician contact the Division of Child Welfare at 315 South Carroll Street, Madison, Wisconsin.

POSTMORTEM EXAMINATION

A great deal of confusion has always existed about whose consent is required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Now, under the law, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Disability Evaluation

By CHESTER C. SCHNEIDER, M. D.
Milwaukee

DISABILITY evaluation is not an exact science resting on mathematical rules which will inevitably produce the same conclusion irrespective of who operates the formula. The conclusions reached vary with the evidence and the significance attached to it, the previous experience of the expert, and the condition and reaction of the patient. Given the same facts, even conscientious experts can disagree about their significance, so the disagreement between experts does not imply dishonesty or incompetence on their part.

Appraisal of injuries and their immediate and future disability producing potentials is a complicated and important subject. It requires extensive knowledge of all diagnostic procedures necessary to evaluate the exact nature of the injury and the probable consequences of natural healing and degenerative changes over the remaining life of the patient. The expert must study the problem with an open mind, determined to assemble all the facts necessary for the establishment of a correct diagnosis and a fair and complete comprehension of all relevant matters. Too often prejudicial factors resulting from biased attitudes, limited and unbalanced experience, preliminary prejudicial conferences with lawyers or adjusters, too zealous a desire to be helpful to the interests being served, and hostile or ingratiating patient attitudes consciously or unconsciously channel the conclusions which he reaches. This is particularly true where the objective findings are in contrast with the subjective complaints and frequently accounts for the wide disagreement between otherwise honest and sincere experts.

After accurately assembling all the necessary information required to establish a diagnosis and to form the basis for an opinion, the expert must prepare a report which is clear, concise, adequate for its intended purpose, unpadded with unnecessary and irrelevant data and narration, and completely understandable. The preparation of an entirely satisfactory report is an art which every physician should assiduously practice throughout his career. He must bear in mind that the report is his sole agent in these matters and, if it does not impress the reader as being neat, thorough, well prepared, and understandable, it will fall short of its objective. The physician should know what is to be said and say it as clearly and briefly as possible. He should also put enough punch into his opinion to reflect solidity of character, and he should rest his conclusions on facts, accurately established, clearly set forth, and logically evaluated.

Traumatic situations in general may be subdivided into four large groups:

1. Those with no objective evidence of injury and no underlying defects or disease of antecedent origin.
2. Those with no evidence of injury but with underlying defects or disease of long standing.
3. Those with evidence of injury and no associated antecedent defects or disease, and
4. Those with evidence of injury and also with associated long standing defects or disease.

Obviously each of these groups requires different analysis and leads to divergent conclusions.

In Wisconsin and other states, helpful basic tables have been prepared by the Industrial Commission to guide the physician in estimating disability; these should be studied. They set forth the value of amputations at all joints of the extremities, the relative loss of function due to complete and partial loss of motion at each of these joints in various positions, the value of partial and complete loss of sight and hearing, and the disability due to reduction of length of the lower extremities. Through the aid of these tables, even defective conditions not included can be appraised by computing their disabling effect in relation to the tabulated conditions. The disability may vary according to special features that produce functional loss. Pain, loss of sensation, weakness, mechanical disadvantages, and reduced endurance must be added to disability for limitation of motion.

Every physician is perplexed and frequently confused by the patient with many complaints unsupported by objective evidence of recent injury and no antecedent disease. These purely subjective situations cause conflict of expert opinion. The conscientious expert must support his conclusions by substantial findings, and consequently his position becomes untenable when he assumes the existence of pain and disability without objective defects to explain them. Cautious and well trained experts will not allow themselves to be misled by the patient whose symptoms will vanish after the litigation has terminated. In these cases a conservative and reasonable attitude is safest, and the expert will do well to confine himself to a statement of the complete absence of objective findings, if that is the case, and to an opinion as to the existence of the alleged dysfunction and pain under the existing circumstances. It must, of course, be conceded that pain and disability can exist without detectable physical findings, and the expert must be aware of these possibilities and qualify his statements accordingly.

Injuries which disturb the circulation of vital structures often lead to slowly evolving defects which cannot be detected for months or years after the accident. Disc injuries in the neck or lower back, damage to articular cartilages in various joints, damaged nutrition to small bones of the wrist, and many other similar conditions are almost impossible to detect in their early stages and require careful investigation to diagnose. Until the tell-tale signs and symptoms of late degeneration appear, the expert can only suspect the underlying situation and advise delay in the final disposition of the matter.

Many cases of alleged disability following accidents occur in individuals who show no evidence of traumatic structural defects but in whom more or less advanced pathologic conditions of long-standing can be found. These include architectural defects of developmental or congenital origin which can easily be rendered symptomatic by an accident, even though they had been completely silent prior to that time. Structural defects in the lower back are peculiarly prone to become symptomatic after sprain, and it is amazing and disconcerting to note how unresponsive to normal healing such injuries can be. Chronic arthritis is another condition which may smolder silently for years only to be rendered painful by some relatively minor injury. Symptoms which may have been present but disregarded by the patient for a long time suddenly assume striking importance and cause great annoyance after a compensable accident. Grating or grinding of the bones in the neck is a most common phenomenon in middle-aged and elderly people, rarely causing apprehension or inconvenience until some slight accident has occurred, and then the patient regards the same symptom as proof of a serious injury with permanently disabling potentialities. Many people forget, or have learned to disregard, the consequences of an old non-compensable injury until the same area is reinjured under compensable circumstances. Then all the effects of the ancient injury are suddenly attributed to the recent one. In such instances the expert must exercise great care to segregate the old from the new.

Traumatic aggravation of chronic smoldering disease most certainly can occur. Influences inadequate to injure normal tissues can affect defective ones. These reactions are usually persistent and do not respond to treatment. They must be recognized and appraised in accordance with the experience of similar cases.

Injuries of the back have long been known for their difficulty of determination and evaluation. "Railroad spine," "sacro-iliac sprain," and more recently "disc lesions" have successively plagued the medical profession. This is due to the great frequency of injuries to the spine, the complicated anatomy of this region, and the relative ease of misrepresentation of symptoms which they permit. Often they do not disclose themselves by definite, objective signs. Even the x-ray and other special diagnostic facilities cannot always reveal evidence of injury. Consequently appraisal of injuries of the spine requires not only the most conscientious and searching investigation of the patient, including many special diagnostic methods, but demands also careful observation of the patient himself and his reaction to many special tests. In one way or another every tissue under suspicion can be subjected to investigation, and the complex picture of actual injury recorded. If the findings are consistent and logical, the conclusions are definite and irrefutable, but if they are confused and inconsistent, they arouse suspicion and doubt.

Injuries of the spine have strikingly contrasting potentialities. A wrenched neck may merely stretch a muscle or ligament causing only temporary discomfort and no permanent residuals or, it may fracture an intervertebral disc and lead to interminable trouble. A "broken back," so-called, may be only a cracked appendage of one of the vertebrae, or it may be a crushed vertebral body with or without paralysis from injury of the spinal cord. A "low back strain" or sprain may be a minor muscle stretch, or it can be a ruptured intervertebral disc, with or without protrusion of disc material into the spinal canal. This latter condition can, and frequently does, lead to chronic changes in the disc, maladaptation of the vertebrae to each other, instability of the lower spine, chronic back ache, sciatic nerve irritation, and even partial paralysis. All of these conditions can be diagnosed by careful examination including the use of x-rays, spinal puncture, injection of oil or air into the subarachnoid space, and special physical and laboratory tests. If an injury actually has occurred, the expert by means of a competent examination will be able to find evidence of it. If he does not obtain conclusive evidence of an injury or if the findings are inconsistent, he is justified in presuming that no abnormality is present. Often the patient's unsupported allegations represent only a part of the picture of his insincerity and unreliability.

Another feature of the spine which often leads to confusion is the presence of structural defects of congenital or developmental origin, which closely simulate those caused by trauma. Thus, wedge-shaped vertebrae (Scheuermann's Disease, Calve's disease, hemivertebrae, etc.), unattached portions of vertebral bodies (limbus vertebrae, unattached transverse spinous processes, unattached articular processes, etc.), unfused interarticular portions of vertebrae (spondylolysis, etc.), and many other defects may either be the result of congenital or ancient acquired abnormality or recent trauma. The physician who wishes to qualify as an expert must be able to differentiate these conditions.

University Hospitals

IN ORDER to properly characterize and at the same time to avoid confusion, the single term, University Hospitals, is presently being used with the following designated units included under this grouping.

Student Infirmary
Mary Cornelia Bradley Memorial Hospital
State of Wisconsin General Hospital
Wisconsin Orthopedic Hospital for Children
Cancer Research Hospital

According to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $16.00 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full cost.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on $16.00 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $16.00 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

Patients are also seen in the Outpatient Department of the Hospitals upon reference from the family physician or official agency. Registration fees for most outpatient clinics follow:

Public Patient	$ 1.00
Special Rate Patient	5.00
Private Patient	10.00

These fees cover the hospital charges *only* and do not include professional fees if they are applicable.

A similar schedule of fees for the Tumor Clinic has been established.

For the Easter Seal Cerebral Palsy Center, the fees are as follows:

Public Patient	$ 1.00
Special Rate Patient	7.50
Private Patient	15.00

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Units of University Hospitals

State of Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital and with the approval of the Crippled Children's Division.

The Mary Cornelia Bradley Memorial Hospital for Children: This is the Pediatric Department of the State of Wisconsin General Hospital and is not a separate unit.

University of Wisconsin Student Infirmary: Student health center and hospital.

Cancer Research Hospital: An integral part of the additions to the State of Wisconsin General Hospital, dedicated by the National Institutes of Health in January 1952.

Wisconsin Psychiatric Institute: The laboratory facilities of the Psychiatric Institute will be taken over by the State Laboratory of Hygiene when it opens its new building on the campus. The other functions of the Institute will be incorporated in the Diagnostic Center which is presently being erected.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

TAX DEDUCTIONS FOR HEALTH EXPENSES

Following is a summary of the principal provisions of the state and federal income tax laws relating to the deductibility of health expenses of the tax payer and his immediate family.

1. *Federal Law.* Among the items deductible are medical, dental, drug, nursing, hospital, x-rays, travel directly related to hospitalization, including, in the case of a helpless patient the travel expenses of a parent or another companion. "Premiums for insurance policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however." To be deductible, *such expenses must be actually paid,* not merely incurred during the tax year.

Only those health expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. Such expenses are *not* allowable up to an amount equal to 5 per cent of such adjusted gross income. For maximum health deductions and fuller treatment of this subject in the federal statute see the *Wisconsin Medical Journal,* December 1952, page 1205.

2. *Wisconsin Law.* Medical, surgical, dental, hospital, nursing, and other healing services and the cost of drugs and medical supplies incurred by the tax payer on account of sickness or of personal injury to himself or his dependents are deductible *if paid* during the tax year, for total amounts in excess of $50.00, but not exceeding $500.00. In other words, the first $50.00 of health expenses of a Wisconsin income tax payer and his dependents is not allowable, nor is any excess of such expenses over $500.00. "The same rule set forth above under Federal Law applies to Wisconsin income taxpayers insofar as deductions for health and accident insurance premiums are concerned." This point is also to be found in the income tax article in the *Wisconsin Medical Journal,* December, 1952, page 1205.

EPILEPTICS AND THE STATE MOTOR VEHICLE DEPARTMENT

No one who is subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin, except under the following conditions:

If an epileptic is under medical care, however, and while under medication is free from seizures, and his driving is not otherwise a hazard to public safety, he may be issued a temporary license, which must be recertified each six months. Section 85.08 (6) (j) of the Wisconsin Statutes, enacted during the 1949 session of the Legislature, provides that any physician licensed in this state may recommend such a temporary license for a patient on a combined questionnaire and recommendation form provided by the Motor Vehicle Department.

The issuance of a temporary license, predicated upon such a recommendation by the physician rendering treatment, is discretionary with the Motor Vehicle Department, but a denial may be reviewed by a special board, two of the three members of which are designated by the president of the State Board of Health.

Disability Plan for Doctors Enters Third Successful Year New Members of Society Urged to Enroll

FROM time to time *The Wisconsin Medical Journal* has carried articles concerning the group accident, sickness, and hospitalization insurance program instituted for members of the Society in August of 1950. Since about 80 per cent of eligible physicians are enrolled in the plan, a report of its continuing success will be of interest to all Society members.

Benefits paid to insured physicians by the plan's underwriter, the Provident Life and Accident Insurance Company, total well over $300,000, this sum representing a contribution to the economic security of Wisconsin doctors made possible only by the action of your Society. Claims for disability benefits have been settled promptly and equitably. In view of the fact that the master policy provides for investigation and review by the State Medical Society of any disputes between a claimant physician and the insurance company, it is interesting to note that only a handful of cases have been drawn to the attention of the Group Insurance Committee, and that most of these have been at the request of the insurance company for administrative opinions.

The ratio of the dollar amount of benefits paid to the amount of premiums charged, over and above the insurance company's administrative expense and reserves set aside for pending and future claims, indicates that most of the premium fund is returning to enrolled physicians in the form of benefits.

It is the only disability insurance program officially sponsored by the State Medical Society. During the past two years, the Wisconsin group disability insurance plan has drawn national attention; and, in pioneering certain features of this form of income protection, it has served to increase materially the number of group insurance policies available to the medical profession through other state societies and the national specialist academies and colleges. These have been examined critically. So far as is known, the Wisconsin program continues to offer the most in income protection benefits per dollar of premium charged.

The success of the Society's plan is the direct result of the high rate of member participation in it. Since making this protection available under such favorable rates and conditions is a vital service of the Society to its members, every effort is made to secure the enrollment of new members and to maintain the interest of those already covered. The Society asks that new members study the insurance outline, which is furnished to them. New members of the Society who are under age 32 may apply within one year and members over age 32 within six months, without consideration of present physical condition or past medical history.

A question frequently raised concerning the plan is whether or not the insurance company may cancel the coverage of an individual doctor. The insurance certificate of the individual physician cannot be cancelled, except in the following cases: nonpayment of premium; attainment of age 75; ceasing to be an active member of the medical society or in the active practice of medicine; or the cancellation by either the Society or the insurance company of the master contract. The master contract can be cancelled only on the annual renewal date, and then only on notice of at least 60 days.

Another possible question concerns the reasons for arranging the two year limit for sickness disability and that of five years for accident. Insurance disability tables show that the chances of incurring a disability lasting more than two years are only one-sixth of 1 per cent, and more than five years are only one-twelfth of 1 per cent. It should be noted that in creating this plan to the Society's own specifications, the prime consideration was to satisfy the need for a *basic* coverage to assist the younger physician in establishing his personal insurance program, by taking advantage of the Society's collective purchasing power which makes possible broad coverage at minimum rates.

The presentation and enrollment efforts have been handled largely by mail and with a minimum of inconvenience to the membership. Detailed information is supplied periodically to new members during their periods of non-medical eligibility, and from time to time all uninsured physicians are reminded of the availability of this protection.

During the past year a letter from Dr. A. H. Heidner, president of the Society, contained the following observations:

1. "To the best of our knowledge, it is the finest Group Disability Plan—in terms of benefits per premium dollar—available to the medical profession today."
2. "The great majority of eligible members participate in the Plan, evidencing its need and value as a service of your Society."
3. "The hundreds of thousands of dollars paid to members during the short time it has been in force are an important contribution to the economic security of Wisconsin doctors."
4. "By actively sponsoring this Plan for its own members, the State Medical Society of Wisconsin publicly demonstrates the soundness and practicability of privately operated, voluntary welfare programs—as is consistent with our announced policy."

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

The State Medical Society of Wisconsin

1953 Officers and Councilors

President

Dr. J. C. Griffith
944 North Jackson Street
Milwaukee

President-Elect

Dr. H. Kent Tenney
1 South Pinckney
Madison

Secretary

Mr. C. H. Crownhart
704 East Gorham Street
Madison 3

Assistant Secretary

Mr. Roy T. Ragatz
704 East Gorham Street
Madison 3

Treasurer

Dr. F. L. Weston
1300 University Avenue
Madison 6

Speaker, House of Delegates

Dr. G. E. Forkin
108 Main Street
Menasha

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. H. Costello, Beaver Dam, 1954.

Second: Kenosha, Racine and Walworth County Societies. Dr. T. C. Hemmingsen, 1332 State Street, Racine, 1954.

Third: Dane, Columbia-Marquette-Adams, Green, Rock and Sauk County Societies, Dr. N. A. Hill, 304 West Washington Avenue, Madison 1955; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1954.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1955.

Fifth: Calumet, Manitowoc, Sheboygan and Washington-Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1955.

Sixth: Brown-Kewaunee-Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. A. J. McCarey, 610 Northern Building, Green Bay, 1955.

Seventh: Juneau, La Crosse, Monroe, Trempealeau-Jackson-Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavia Bank Building, La Crosse, 1953.

Eighth: Marinette-Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Peshtigo, 1953.

Ninth: Clark, Green Lake-Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. E. E. Kidder, 313 Main Street, Stevens Point, 1953.

Tenth: Barron-Washburn-Sawyer-Burnett, Chippewa, Eau Claire-Dunn-Pepin, Pierce-St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman) Frederic, 1953.

Eleventh: Ashland-Bayfield-Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1954.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 1227 West Lincoln Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee; Dr. N. J. Wegmann, 2510 West Capitol Drive, Milwaukee, 1954; Dr. W. T. Casper, 2218 North Third Street, Milwaukee, 1955.

Thirteenth: Forest, Langlade, Oneida-Vilas and Price-Taylor County Societies. Dr. C. E. Zellmer, Antigo, 1953.

Dr. A. H. Heidner, West Bend.

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. S. E. Gavin (1954)
104 South Main Street
Fond du Lac

Dr. W. D. Stovall (1953)
Service Memorial Institute
Madison 6

Dr. D. H. Witte (1954)
3300 West Wisconsin Avenue
Milwaukee

Alternates

Dr. L. O. Simenstad (1954)
Osceola

Dr. Joseph C. Griffith (1954)
944 North Jackson Street
Milwaukee

Dr. D. J. Twohig (1953)
Fond du Lac

---

* Map indicating location of councilor districts, page 91.

Standing Committees—1952-1953

Committee on Cancer

A. R. Curreri, M.D., 1955, chairman, 1300 University Avenue, Madison

W. S. Bump, M.D., 1953, 1020 Kabel Avenue, Rhinelander

James E. Conley, M. D., 1953, 425 East Wisconsin Avenue, Milwaukee

D. C. Beebe, M.D., 1953, Sparta

S. L. Henke, M.D., 1953, 314 East Grand Avenue, Eau Claire

J. W. Conklin, M.D., 1953, Platteville

G. C. Schulte, M.D., 1953, 7221 Third Ave., Kenosha

A. C. Taylor, M.D., 1954, 103 West College Avenue, Appleton

R. P. Welbourne, M. D., 1954, 113 North Third Street, Watertown

P. B. Blanchard, M.D., 1954, Cedarburg

W. E. Bargholtz, M.D., 1954, 522 West Second Street, Ashland

K. G. Pinegar, M.D., 1955, 1723 Main Street, Marinette

R. B. Larson, M.D., 1955, 510 Third Street, Wausau

Committee on Grievances

R. E. Fitzgerald, M.D., 1954, chairman, 2218 North Third Street, Milwaukee 12

E. W. Mason, M.D., 1953, 324 East Wisconsin Avenue, Milwaukee 2

E. D. Sorenson, M.D., 1953, Elkhorn

C. E. Zellmer, M.D., 1954, Antigo

F. A. Nause, M.D., 1955, 927–A North Eighth Street, Sheboygan

H. W. Wirka, M.D., 1955, 1300 University Avenue, Madison

Committee on Hospital Relations

Karl H. Doege, M.D., 1953, chairman, 650 South Central Avenue, Marshfield

Gorton Ritchie, M.D., 1953, Columbia Hospital, Milwaukee 11

A. H. Barr, M.D., 1954, 214 North Wisconsin Street, Port Washington

S. R. Beatty, M.D., 1954, Mercy Hospital, Oshkosh

W. B. Hildebrand, M.D., 1955, 216½ Main Street, Menasha

O. V. Overton, M.D., 1955, 58 South Main Street, Janesville

Committee on Medical Education and Hospitals

T. L. Squier, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee 2

A. H. Heidner, M.D., 1953, West Bend

Norman Becker, M.D., 1954, 104 South Main Street, Fond du Lac

J. W. Boren, Jr., M.D., 1955, 1510 Main Street, Marinette

A. P. Zlatnik, M.D., 1957, 1421 Seventeenth Street, Two Rivers

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

Committee on Coordination of Medical Services

S. B. Harper, M.D., 1953, chairman, 1 South Pinckney Street, Madison 3

W. H. Costello, M.D., 1954, Beaver Dam

T. W. Tormey, M.D., 1955, 16 North Carroll Street, Madison 3

S. E. Gavin, M.D., 1956, 104 South Main Street, Fond du Lac

J. F. Wilkinson, M.D., 1957, 114 East Wisconsin Avenue, Oconomowoc

President, ex officio

Secretary, ex officio

Council on Medical Services

D. E. Dorchester, M.D., 1954, chairman, 10 North Third Avenue, Sturgeon Bay

T. D. Elbe, M.D., 1953, Thiensville

L. O. Simenstad, M.D., 1953, Osceola

D. N. Goldstein, M.D., 1953, 625 Fifty-Seventh Street, Kenosha

R. L. MacCornack, M.D., 1954, Whitehall

C. G. Reznichek, M.D., 1954, 2037 Winnebago Street, Madison 4

D. M. Willison, M.D., 1955, 314 East Grand Avenue, Eau Claire

J. S. Devitt, M.D., 1955, 944 North Jackson Street, Milwaukee 2

W. J. Fencil, M.D., 1955, The Monroe Clinic, Monroe

Committee on Public Policy

J. M. Sullivan, M.D., 1957, chairman, 161 West Wisconsin Avenue, Milwaukee

J. R. Schroder, M.D., 1953, 500 West Milwaukee Street, Janesville

J. A. Enright, M.D., 1954, 720 North Jefferson Street Milwaukee 2

S. E. Gavin, M.D., 1955, 104 South Main Street, Fond du Lac

J. K. Curtis, M.D., 1956, 110 East Main Street, Madison 3

President, ex officio

President-elect, ex officio

Secretary, ex officio

Council on Scientific Work

T. O. Nuzum, M.D., 1953, chairman, 500 West Milwaukee street, Janesville

J. W. Gale, M.D., 1954, 1300 University Avenue, Madison 6

P. A. Midelfart, M.D., 1955, 314 East Grand Avenue, Eau Claire

S. A. Morton, M.D., 1956, 3321 North Maryland Avenue, Milwaukee 11

M. G. Rice, M.D., 1957, 401 Main Street, Stevens Point

R. S. Baldwin, M.D., ex officio, 650 South Central Avenue, Marshfield

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

Council Committees

The following committees are committees of the Council. Appointments are made by the chairman of the Council following its annual meeting in February, and names of committee members are published in the March issue of the *Journal.*

Advertising

Advisory to the Department of Veterans Affairs

Audit and Budget

Blood Bank

Civil Defense

Commission on Prepaid Plans

Commission on State Departments

Editorial Board

Historical

Interim Committee

Military Medical Service

Polio Consultants

Veterans Medical Service Agency

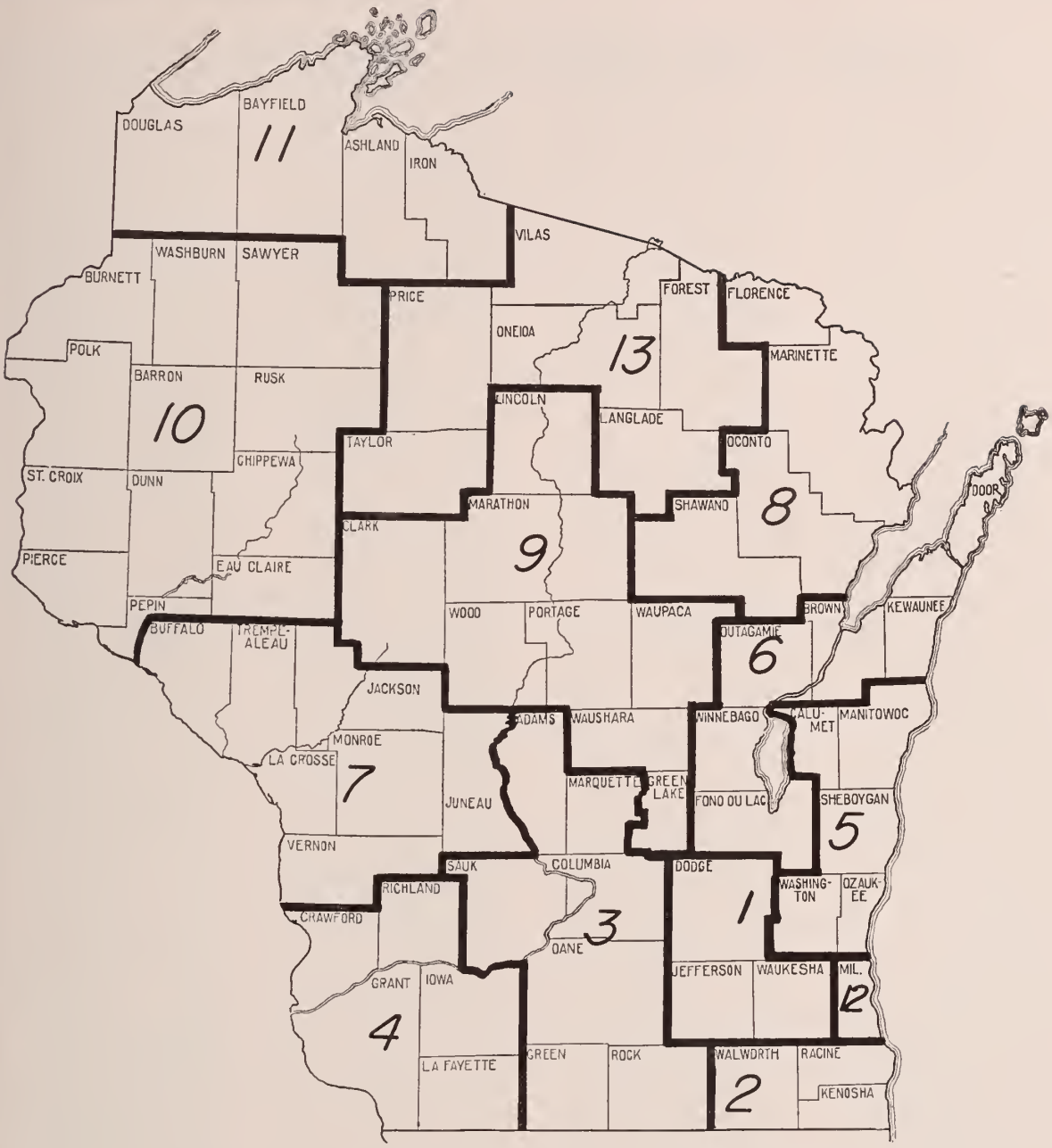
SALARY CEILINGS AND DOCTORS

The wage and salary regulations which exempt from wage and salary control all employees in businesses and establishments employing eight or less persons, effective July 30, 1952, for all practical purposes eliminated salary and wage control in so far as physicians are concerned. It will be a rare case where a physician is one of more than eight employees of a private firm of physicians.

Previous to this time wages, salaries and other compensation paid to physicians employed in a professional capacity by licensed hospitals, clinics, and like medical institutions for the care of the sick and disabled had been exempt.

Questions may still arise, under wage and salary control, in the case of physicians employed by private corporations such as insurance companies. However, these are the exception rather than the rule.

Not only does the exemption in favor of all establishments employing eight or less persons have the practical effect of exempting physicians who are employed, but it also applies to technicians and secretaries as well.



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. W. H. Costello, Beaver Dam

Second District:
Dr. T. C. Hemmingsen, Racine

Third District:
Dr. N. A. Hill, Madison
Dr. H. E. Kasten, Beloit

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. A. J. McCarey, Green Bay

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Peshtigo

Ninth District:
Dr. E. E. Kidder, Stevens Point

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. N. J. Wegmann, Milwaukee
Dr. W. T. Casper, Milwaukee

Thirteenth District:
Dr. C. E. Zellmer, Antigo

Dr. S. E. Gavin, Chairman emeritus, Fond du Lac

Members, State Medical Society of Wisconsin*

Abbotsford:
Shields, G. G.

Adams:
Ingersoll, R. S.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Kremser, V. C.
Marra, M. G.
Whitlark, F. L.

Amherst:
Osicka, S. R.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J
Dorzeski, E. F.
Garbisch, F. H.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Thomas, W. C.
Zellmer, C. E.

Appleton:
Adrians, W. A.
Aldridge, C. W., Jr.
Benton, J. L.
Bolton, E. L.
Carlson, G. W.
Cunningham, P. M.
Dafoe, W. A.
DeCock, R. D.
Dehne, W. O.
Felton, W. C.
Frawley, W. J.
French, G. A.
Gallaher, D. M.
Giffin, W. S.
Gloss, A. J.
Gmeiner, J. E.
Gross, H. T.
Haentzschel, L. E.
Harrington, Wm. J.
Hauch, F. M.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McBain, L. B.
Mielke, E. F.
Neidhold, C. D.
Pardee, C. A.
Rankin, F. J.
Reeve, J. S.
Skibba, J. P.
Swanton, M. E.
Talbot, A. E.
Taylor, A. C.
Williams, L. P.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Weber, F. T.

Argyle:
Thompson, L. L.

Arpin:
Ryan, C. J.

Ashland:
Andrus, A. D.
Bargholtz, W. E.
Butler, Albert
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Jauquet, J. M.
Kreher, J. E.
Merrill, W. G.
Prentice, J. W.
Sandin, H. V.
Smiles, C. J.
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.
Bachhuber, H. M.

Avoca:
Reynolds, Bertha

Augusta:
Emanuel, D. E.
Moland, O. G.
Thieda, E. S.

Bailey's Harbor
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Carstens, E. H.
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Tryon, F. E.
Vander Kamp, Harry

Barron:
Fostvedt, G. A.
Guy, J. R.
Mahaffey, C. H.
Radke, Lucille M.
Strang, C. J.
Templeton, H. M.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Corso, Xavier
Costello, W. H.
Davis, T. C.
Drescher, G. G.
Foley, M. E.
Hoyer, A. A.
Hoyer, E. C.
Kores, A. B.
Qualls, C. L.
Roberts, R. R.
Rosenheimer, A. M.
Schoen, R. F.
Urbanek, R. E.
Way, R. W.
Webb, E. P.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Belmont:
Turgeson, J. F.

Beloit:
Allen, W. J.
Baldwin, R. M.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Crone, V. D.
Fitzgerald, W. M.
Flarity, T. H.
Fosse, Benjamin
Friend, L. J.
Glesne, O. G.
Gunderson, R. H.
Helm, H. M.
John, G. W.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Raube, H. A.
Rechlitz, E. T.
Ross, M. E.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Thompson, I. F.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

Berlin:
Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J.

Big Bend:
Boldt, R. E.

Birnamwood:
Damp, O. E.

Black Creek:
Smith, P. W.

Black River Falls:
Krohn, Robert
Marks, J. R.
Noble, J. H.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Clauson, C. T.
Hudek, D. F.

Bloomington:
Brooks, E. H.
Edwards, P. K.

Bonduel:
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
Hayman, C. S.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

Boyceville:
Williams, A. E.

Brandon:
Lautenbach, E. T.

Brillion:
Guthrie, J. M.
Langmack, W. A.

Brodhead:
Stovall, W. D., Jr.
Stuessy, M. W.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Bennett, J. F.
Carroll, J. H.
Erickson, L. W.
Granzeau, H. W.
Mastalir, L. O.
Newell, F. F.

Butler:
Schoeneman, R. H.

Cadott:
Haines, B. J.
Zenner, C. E.

Cambria:
Pavelsek, J. W.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J.
Majeski, H. E.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cecil:
Campbell, E. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.

Cedar Grove:
Jensen, J. S.
Voskuil, Anthony

Centuria:
Noyes, G. B.

Chaseburg:
Richter, J. R.

Chetek:
Adams, R. W.
Balken, J. B.

Chilton:
Goggins, J. W.
Humke, E. W.
Humke, K. R.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

Chippewa Falls:
Brown, F. J.
Field, Merton
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. J.
Henske, W. C.
Janc, W. F.

* As of December 15, 1952.

Kelly, J. A.
Kemper, C. A.
McHugh, F. T.
Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Williams, S. E.

Clear Lake:
Campbell, L. A., Jr.

Cleveland:
Feider, A. P.

Clinton:
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Bolinske, R. E.
German, J. D.
Miller, E. A.
Mulvaney, J. J.
Pfeifer, R. H.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Christofferson, H. H.
Nelson, F. F.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.
Poser, R. F.

Cornell:
Foster, T. D.
Rahn, B. F.

Crandon:
Moffet, D. V.
Rathert, Berton S.

Cross Plains:
Froggatt, W. E. L.
Lappley, W. F.

Cuba City:
King, C. S.
Terry, R. E.

Cudahy:
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Kash, S. H.
Landsberg, Manfred
Partridge, C. D.
Tolwinsky, Nathan

Cumberland:
Lund, R. E.
Lund, S. O.
Pfeiffer, L. R.
Thompson, R. C.

Darien:
Truex, G. O.

Darlington:
McConnell, E. D.
McGreane, N. A.

Deerfield:
Ingwell, C. L.

De Forest:
Cooney, R. T.
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Jacobson, T. L.
Levin, H. M.
Moses, R. A.
O'Keefe, F. L.
Werbel, H. J.

Denmark:
Hering, G. V.
Hipps, C. J.
Michna, C. T.

De Pere:
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Hamilton, W. P.
Jackson, S. C.
Morton, H. H.
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Notbohm, W. R.
Watry, T. D.

Durand:
Bryant, R. J.

Eagle River:
Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Anderson, F. G.
Beebe, G. W.
Blom, Julius
Buckley, R. A.
Cameron, W. G.
Dasler, T. W.
Derge, H. F.
Durham, R. A.
Falstad, C. H.
Ferguson, E. C.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
McAffee, G. D.
Midelfart, Peter
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Strand, R. C.
Tanner, J. W.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Martineau, J. E.

Elkhorn:
Bertolaet, E. E.
Bill, K. C.
Helmbrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.

Ellsworth:
Aanes, A. R.

Elm Grove:
Grade, J. O.
Schmidt, E. A.
Zurheide, H. J.

Elmwood:
Springer, F. A.
Springer, J. P.

Elroy:
Demke, R. L.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.

Fond du Lac:
Becker, N. O.
Borsack, K. K.
Cerny, F. J.
Devine, H. A.
Devine, J. C.
Flanagan, C. M.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kief, H. J.
Leonard, C. W.
Mauthe, Howard
McCabe, L. B.
McCormick, D. W.
McCullough, James C.
Meiklejohn, D. V.
Pallin, Josephine J.
Pawsat, E. H.
Peterson, C. R.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Twohig, J. E.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Willson, D. D.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Russell, J. C. H.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elliott, E. S.

Franksville:
Dockery, J. N.

Frederic:
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Jegi, H. A.
Rohde, E. P.

Gays Mills:
Boyce, S. R.
Schott, O. J.

Genoa City:
McNeel, Laird

Gillett:
Bailey, D. M.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Glidden:
Ansfield, F. J.

Goodman:
Maginn, R. J.

Grafton:
Pelant, K. F.

Grantsburg:
Hartzell, R. L.
Lindberg, C. O.

Green Bay:
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Burns, Robert W.
Clark, E. V., Jr.
Cowles, R. L.
Daley, E. F.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dockry, P. F.
Dupont, A. J.
Ford, J. L.
Ford, W. W.
Frank, Herbert
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, D. F.
Gosin, F. J.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hitch, O. M.
Icks, K. R.
Jordan, E. M.

Kane, Elizabeth D.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kispert, R. W
Klobucar, J. J.
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Leaper, W. E.
Levitas. I. E.
McCarey, A. J.
McDermott, J. F.
Miller, L. C.
Milson, Louis
Minahan, P. R.
Mokrohisky, S. M.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V. F.
Olmsted. A. O.
Paine, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
Schmidt, R. T.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Sullivan, Donel
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Urban, Frank

Green Lake:
Leininger, A. T.

Greendale:
Brown, R. J.
Curtin, J. J.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Larsen, L. L.
Pierce, D. F.
Wolf, R. C.

Hartford:
Hoffmann, J. G
Hoffmann, W. C.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Bergwall, R. P.
Hansen, R. T.
Ridley, J. F.
Samuelson, Clarence
Schelble, J. A.

Hayward:
Callaghan, D. H.
Krueger, E. R.
Wyant, M. E.

Hazel Green:
Rosmann, H. K.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Froehlke, T. P.
Leuther, P. A.
Sanford, L. L

Hixton:
Petzke, E. A.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.

Hortonville:
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Livingstone, J. W.
Newton, J. E.
Nuebel, C. J.

Hurley:
Bonacci, M. J.
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Peterson, C. F.

Iola:
Haman, K. L.
Wiley, R. H.

Jackson:
Albrecht, J. E.

Janesville:
Bartels, G. W.
Baumgartner. M. M.
Chasten, S. M.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gutmann, G. E.
Hanlon, P. E.
Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
Nuzum, T. O.
Nuzum, T. W.
Odland, P. K.
Overton, O. V.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroder, John R.
Schroeder, Jack D.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Waufle, G. C.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Caswell, H. O.
Garding, C. J.
Quandt, R. W.
Robinson, A. H

Johnson Creek:
Wendt, F. A

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Flanagan, G. J.
Russo, J. G.

Kenosha:
Ambro, P. J.
Andre, E. F.
Ashley, R. W.
Ashley, T. W.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Braun, W. E.
Creighton, L. H
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hill, B. Spaulding
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
La Macchia, R. M.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Morrow, C. A.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Pirsch, Margaret V.
Powell, R. A.
Randall, A. J.
Rauch, A. M.
Rauen, L. M.
Richards, C. G.
Richards, J. N.
Rufflo, A. F.
Sattler, C. A.
Schlapik, Alexander
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Ulrich, C. F.
Weber, G. R.
Williams, F. C., Jr.

Kewaskum:
Edwards, R. G
Raschbacher, J. L.

Kewaunee:
Nesemann, R. M.
Witcpalek, E. W.
Witcpalek, W. W.

Kiel:
Nauth, D. F.
Twohig, G. J.

King:
Hathaway, G. J.
Montgomery, R. C.

Kohler:
Gascoigne, C. C.
Heinz, H. N.

La Crosse:
Bach, A. C.
Beutler, T. V.
Bruder, V. F. J.
Buchman, D. M.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Dixon, W. G.
Doyle, D. F.
Egan, G. J., Jr.
Egan, J. F.
Ernst, F. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C
Gilbert, R. L.
Gorenstein, L. M.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B.
Gundersen, T. E.
Harman, J. C.
Harris, H. W.
Heraty, J. E.
Hulick, P. V.
Jones, W. J.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
O'Meara, M. T.
Parkin, E. M.
Perry, E. L.
Phillips, P. W.
Ramlow, R. W.
Reay, G. R.
Ridout, G. B.
Satory, J. J.
Schaefer, Margaret A.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Sivertson, Martin
Sivertson, S. E.
Skemp, A. A.
Skemp, G. E.
Skemp, J. T.
Smith, D. S.
Swarthout, Edyth C.
Townsend, E. H.
Uhrich, G. I.
Wolf, F. H.

Ladysmith:
Bauer, W. B A.
Bennett, R. P.
Lundmark, L M.
Murphy, J. E.
Pagel, H. F.
Smith, Woodruff

La Farge:
Gollin, F. F.

Lake Geneva:
Bischof, H. F.
Brady, C. J.
Hudson, E. D.
Jeffers, D. H.

Lake Mills:
Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G
Schoenecker, E. A.
Turcott, R. A.

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Houghton, E. M.
Jackson, R. D.
Kraut, Elgie

Land O'Lakes:
Eickhoff, E. C.

Laona:
Carroll, G. E.
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Curtin, D. W.
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, W. G.

Loganville:
Jewell, E. L.

Lomira:
Fuller, J. D.

Loyal:
Hable, A. P.

Madison:
Aageson, C. W
Albright, E. C.
Allin, R. N.
Allin, T. G., Jr.
Anderson, A. D.
Angevine, D. M.
Ashman, H. C.
Barnes, M. E., Jr.
Becker, R. M.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Bernard, F. D.
Betlach, Dorothy W.
Betlach, E. H.
Bleckwenn, W. J.
Boner, A. J.
Brindley, B. I.
Britton, D. M.
Brown, F. A.
Brown, J. W.
Bryan, A. W.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burns, E. M.
Burns, R. E.
Calvert, Charlotte
Cameron, Eugenia S.
Campbell, R. E.
Canfield, Albert
Carns, Marie L.
Carter, H. M.
Chase, S. L.
Clahassey, E. G.
Clausen, N. M.
Collins, R. F.
Cooksey, R. T.
Coon, H. M.
Cooper, G. A.
Cowle, A. E.
Crumpton, C. W.
Curreri, A. R.
Curtis, J. K.
Davis, A. W.
Davis, F. A.
Davis, F. J.
Davis, Helen P.
Davis, Milton, Jr.
Dean, F. K.
Dean, J. C.
Dean, J. L.
Dean, J. P.
Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Dollard, J. E.
Doolittle, J. W.
Duehr, P. A.
Erickson, T. C.
Ewell, G. H.
Farrell, R. X.
Fauerbach, Louis
Feig, Milton
Filek, A. A.
Fitch, Edna M.
Fogo, A. E.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Fromm, A. H.
Gale, J. W.
Gallagher, J. T. F.
Ganser, W. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Glover, B. H.
Golden, F. F.
Golden, P. B.
Gonce, J. E.
Gordon, E. S.
Greene, H. L.
Grimstad, Frances H.
Grumke, E. H.
Guilford, H. M.
Hamel, Merle O.
Hank, G. C.
Harmon, Doralea R.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Healy, W. G.
Hennen, R. J.
Hibma, O. V.
Hilger, W. A.
Hill, N. A.
Hobbins, W. B.
Hodgson, E. R.
Hoff, A. D.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Hummer, F. L.
Hunter, Amy Louise
Hurlbut, J. A.
Iams, A. M.
Jackson, A. S.
Jackson, R. H.
Jaeschke, W. H.
Joachim, F. G.
Johnson, F. C.
Johnson, S. A. M.
Jones, F. S.
Jorris, E. H.
Kamholz, J. H.
Kant, Fritz
Kay, H. M.
Kincaid, C. K.
Kolman, I. E.
Korst, D. R.
Krehl, W. H.
Kuehn, Eleanor V.
Kundert, P. R.
Kurtz, C. M.
Kurtz, Esther C.
Lacke, C. L.
Land, J. F.
Larkin, C. B.
Larson, F. C.
Lawrence, P. J.
Lemmer, K. E.
Leonard, T. A.
Lewis, R. F., Jr.
Lewis, W. C.
Lindsay, W. T.
Littig, L. V.
Longley, B. J.
Lorenz, T. H.
Lorenz, W. F.
Lubing, H. N.
Ludden, R. H.
Luetke, W. V.
Mahaffey, H. W.
Mailer, A. R.
Malec, J. P.
Maloney, F. G.
Maloof, G. J.
Marsden, W. H
Masten, Mabel G.
McCormick, S. A
McDonough, K. B.
McGary, Lester
McIllece, Patricia E.
McIntosh, R. L
Meanwell, W E
Mehnert, J. H.
Mendenhall, J. T.
Meyer, O. O.
Middleton, W. S.
Miller, J. E.
Mohs, F. E.
Mueller, John J.
Mueller, Joseph J.
Musser, M. J., Jr.
Nause, F. P.
Nereim, T. J.
Nesbit, M. E.
Nesbit, W. M.
Neupert, C. N.
Newman, J. R.
Nordby, E. J.
Oakley, Dorothy H.
Okagaki, H. I.
Olson, D. E.
Oosterhous, G. E.
Orth, O. S.
Osborn, L. A.
Parkin, R. C.
Parks, H. K.
Paul, L. W
Piper, P. G.
Pohle, E. A.
Prouty, Margaret
Puestow, K. L.
Quisling, A. A.
Quisling, R. A.
Quisling, Sverre
Reese, H. H.
Reis, L. N.
Reznichek, C. G.
Rhoades, A. L.
Richtsmeier, A. J.
Ris, Hania W.
Roemer, E. P.
Roessler, R. L.
Rogers, S. C.
Roisum, B. H.
Rotter, Royal
Rutter, Thomas
Salick, J. A.
Sarfatty, I. J.
Schafer, Etheldred L.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schroeder, C. F.
Schubert, C. K.
Schuele, D. T.
Schwittay, Addie M.
Settlage, P. H.
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Siebecker, K. L.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Skroch, E. E.
Soucek, Adolph
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Steeper, J. R.
Stehr, A. C.
Stewart, Katherine E.
Stiennon, O. A.
Stone, Mildred M.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Suckle, H. M.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taborsky, C. R.
Talbert, M. J.
Talbot, J. R.
Tanner, W. A.
Tatum, A. L.
Taylor, F. B.
Tenney, H K.
Tenney, H. K., III
Thornton, Madeline J.
Tormey, A. R.
Tormey, T. W.
Trautmann, Henry
Tweeten, J. K.
Urben, W. J.
Van Duser, A. L.
Van Gemert, J. G.
Vingom, C. O.
Vinograd, S. P.
Wadoell, J. G.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Waters, D. D.
Wear, J. B.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Wilkie, J. M.
Williams, D. L.
Wirig, M. H.
Wirka, H. W
Wixson, R. C.
Worley, Gordon
Wylde, R. M.
Young, W. P.

Manawa:
Irvine, R. K.

Manitowoc:
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
O'Neill, C. J.
Pick, D. M.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rau, G. A.
Rauch, W. A.
Rees, T. H.
Scherping, W. H.
Shaw, Jesse W.
Simenson, R. S.
Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teltgen, Arthur
Teltgen, T. A.
Thorpe, R. F.
Wall, C. E.
Yost, R. G.
Zibel, Milton

Marathon:
Kampine, C. E.

Maribel:
May, J. H.

Marinette:
Bell, J. M.
Boren, C. H.
Boren, Clark H.
Boren, J. A.
Boren, J. W., Jr.
Duer, G. R.
Kirmse, T. W.
Koepp, C. E.
May, J. V.
McCanna, P. R.
Moss, K. J.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Shaw, R. W.
Zeratsky, J. D.

Marion:
McInnis, W. R.
Van Schaick, R. E.

Markesan:
Cupery, D. P.
Pelton, R. S.

Marshfield:
Baldwin, Elizabeth
Baldwin, R. S.
Boeckman, F. A.
Burns, J. L., Jr.
Custer, G. S., Jr.
Doege, K. H.
Doege, P. F.
Epstein, Stephan
Gouze, F. J.
Helland, N. J.
Holmes, C. L.
Mason, R. W.
McCormick, G. L.
Miale, J. B.
Millard, A. L.
Potter, R. P.
Rice, T. J.
Rowe, R. J.
Suits, J. J.
Vedder, C. A.
Vedder, J. S.
Wickham, J. M.
Wink, R. H.

Mauston:
Griffin, V. M.
Hess, J. S.
Tverberg, M. S.
Vedner, J. H.

Mayville:
Bachhuber, F. G
Parish, G. A.
Royce, M. E.

Mazomanie:
Schultz, Isadore

Medford:
Elvis, E. B.
Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Conway, J. E.
Corry, L. F.
Forkin, G. E.
Hildebrand, G. B.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.
Schwei, G. P.

Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.
Hoyt, G. E.
Schloemer, H. F.

Menomonie:
Buckley, C. H.
Cook, F. D.
Drescher, A. A.
Grannis, I. V.
Halgren, J. A.
Lee, S. R.
Lumsden, Wm.
McMahon, A. E.
Mann, G. A.
O'Neill, J. W.
Quilling, P. A.
Steves, B. J.

Mercer:
Ashe, H. S.
Kleinboehl, J. W.

Merrilan:
Schwarz, S. G.

Merrill:
Bayer, L. J.
Bayer, W. H.
Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.

Middleton:
Heighway, T. F.
Stricker, M. F.

Milltown:
Hohf, A. H.

Milton:
Burdick, H. L.
Crosley, G. E.
Davis, M. D.

Milton Junction:
Holmes, J. F.
Vogel, T. L.

Milwaukee:
Ackerman, J. S.
Adamkiewicz, J. J.
Aguirre, M. R.
Albrecht, D. J.
Allen, L. L.
Altmeyer, J. R.
Anderson, P. D.
Anderson, W. A. D.
Ansfield, D. J.
Ansfield, M. J.
Apfelberg, H. J.
Appleby, K. B.
Armbruster, J. L.
Arneth, J. J.
Aszman, P. E.
Ausman, D. C.
Ausman, H. R.
Avellone, B. M.
Axelrod, Sidney
Aylward, T. J.
Babbitt, D. P.
Babbitz, A. L.
Babbitz, S. G.
Babby, Louis
Bach, E. C.
Bach, M. J.
Bach, R. J.
Bachhuber, E. A.
Backus, E. A.
Baier, A. R.
Baker, V. L.
Baldi, J. B.
Baldigo, E. M.
Balistreri, Frank
Bardenwerper, H. E.
Barrock, J. J.
Barta, E. F.
Bartzen, P. J.
Bauch, N. G.
Bauer, C. A.
Bauman, R. O.
Baumann, A. J.
Baumgart, C. H.
Baumle, B. J.
Bechmann, Fred
Becker, I. M.
Becker, R. J.
Beckman, Harry
Behnke, E. J.
Belfus, F. H.
Belknap, E. L.
Bellehumeur, C. E.
Bemis, E. L.
Bender, B. I.
Benjamin, H. B.
Bensman, L. L.
Benton, R. W.
Bercey, J. E.
Bergmann, G. J.
Berner, C. L.
Bernhard, L. A.
Bernhard, V. M
Bernhart, E. L.
Beutler, A. D.
Bickler, E. P.
Bielefeld, Mary E.
Biller, J. H.
Biller, S. E.
Birge, E. A.
Black, S. B.
Blanchard, H. H.
Blankstein, S. S.
Blount, W. P.
Blumenthal, R. W.
Bodden, A. M.
Bolger, J. Victor
Bonan, J. D.
Bookhamer, J. W.
Bordenave, G. J.
Borman, M. C.
Bornstein, Max
Bornstein, S. L.
Bortin, M. M.
Bourne, N. W.
Boxer, L. M.
Boxer, S. M.
Brachman, Louis
Brah, W. A.
Brazy, R. R.
Brewer, B. J.
Brey, P. F.
Brillman, C. R.
Broadbent, Mary
Brook, J. J.
Brown, R. C.
Brunkhorst, R. O.
Brzezinski, E. A.
Budny, C. L.
Bunkfeldt, Frederick
Burden, J. G.
Burns, T. A.
Busby, W. W.
Buscaglia, A. T.
Buscaglia, C. J.
Bussey, A. D.
Buszkiewicz, T. S.
Byrne, R. W.
Byrnes, M. B.
Cahana, Stephen
Callan, P. L.
Callan, R. E.
Calvy, D. W.
Calvy, T. L.
Cannon, H. J.
Carl, E. E.
Carl, E. F.
Carlson, D. J.
Carter, J. M.
Cary, J. F.
Cash, I. I.
Casper, W. T.
Cassidy, R. H.
Ceci, G. E.
Cervenansky, A. A.
Chambers, R. K.
Champney, R. D.
Chandler, W. W.
Chapman, B. L.
Charles, J. D.
Chase, Jules
Chojnacki, S. L.
Churchill, B. P.
Clasen, W. E.
Claudon, D. B.
Cleveland, David
Coffey, S. E.
Coffey, W. L., Jr.
Coheen, J. J.
Collentine, G. E.
Collentine, G. E., Jr.
Collopy, P. J.
Conen, W. J.
Conley, J. E.
Conroy, C. F.
Conway, J. D.
Conway, J. P.
Cook, H. E.
Coon, W. L.
Corcoran, C. J.
Cordes, V. J.
Correll, H. L.
Cowan, I. I.
Cox, J. A.
Craite, E. J.
Cramer, R. P.
Cron, R. S.
Currer, P. R.
Curry, J. C.
Curtis, W. C.
Dall, G. A.
Dallwig, E. L.
Dallwig, H. C.
Darling, F. E., Sr.
Darling, F. E., Jr.
Darling, S. J.
Davidoff, I. Z.
Davies, J. A., Jr.
Davis, D. P.
Dawson, D. L.
Dean, G. W.
Decker, H. G.
Demeter, N. D.
Derse, F. R.
Devitt, J. S.
Diamond, C. O.
Dishmaker, M. C.
Dix, C. R.
Dorn, A. S.
Downes, Virginia
Drew, F. E.
Dricken, H. N.
Drischler, W. H.
Drozewski, M. F.
Duffy, H. R.
Dundon, J. R.
Dunker, G. O.
Dunst, C. G.
Dvorak, H. J.
Eberbach, C. W.
Eby, L. G.
Edelman, Elsa B.
Egan, W. J.
Eichenberger, C. R.
Eisenberg, E. E.
Eisenberg, L. A.
Eisenberg, P. J.
Elconin, D. V.
End, E. M.
End, J. A.
Enright, J. A.
Enzer, Norbert
Epperson, P. S.
Epstein, Eli
Erbes, John
Evans, S. M.
Evrard, J. R.
Faber, C. A.
Fabric, B. L.
Falsetti, F. P.
Fant, J. R.
Farrell, H. J.
Fechter, F. J.
Fechter, F. R.
Feiman, L. H.
Feld, S. M.
Feldman, E. I.
Fellman, G. H.
Fellows, R. M.
Fetherston, J. P.
Fetherston, J. P., Jr.
Fetherston, W. C.
Fidler, Charles
Finn, C. J.
Fisher, Laura M. D.
Fitzgerald, G. F.
Fitzgerald, R. E.
Fitzsimmons, Antoinette V.
Fleischmann, J. A.
Fletcher, H. A.
Flood, R. E.
Flynn, R. T.
Foerster, F. E.
Foerster, H. R.
Foerster, O. H.
Foley, L. J.
Foley, T. J.
Fons, J. W.
Foregger, Richard
Fortier, C. A. H.
Fox, M. J.
Fox, Milton J.
Fox, M. S.
Frackelton, W. H.
Franklin, Emil
Franklin, Isadore
Franklin, S. N.
Frawley, D. D.
Freedman, M. S.
Frey, P. G.
Frisch, R. A.
Froede, H. E.
Froelich, J. A.
Gabor, M. E.
Gaenslen, F. G.
Galasinski, R. E.
Gallimore, R. G.
Garens, R. W.
Garland, J. G.
Garner, L. L.
Garvey, J. L.
Gaspich, R. J.
Gatherum, D. H.
Gaunt, J. J.
Gaynon, I. E.
Gebert, W. H.
Gebhard, U. E.
Gecht, E. A.
Geiger, Sara G.
Gendlin, N. A.
Gertenbach, E. O.
Gilbert, Joseph
Gilchrist, R. T.
Gingrass, R. P.
Glisch, W. P.
Goldberg, Nat.
Goldberger, Esther W.
Goodman, J. A.
Goodman, J. S.
Goodman, P. P.
Goodsitt, A. H.
Gorder, A. C.
Gordon, N. F.
Gorens, S. W.
Gorenstein, Leonard
Gramling, J. J.
Gramling, J. J., Jr.
Greenberg, A. I.
Greenberg, Maurice
Greenwalt, T. J.
Griffith, J. C.
Grossman, N. M.
Grossmann, E. E.
Gruender, J. E.
Guardalabene, Vito
Gudex, V. A.
Guerin, L. H.
Gumerman, G. J.
Gute, E. B.
Gutglass, M. F.
Guzzetta, M. M.
Guzzetta, V. J.
Habbe, J. E.
Habeck, E. A. W.
Haberland, J. E.
Hackbarth, D. E.
Hake, C. B.
Hall, R. M.
Halser, J. G.
Hankwitz, A. W.
Hansen, A. C.
Hansen, H. T.
Hansen, J. W.
Hansher, Ervin
Hanson, E. R.
Hanson, R. A.
Hara, Kinge
Hardgrove, Maurice
Hargarten, L. W.
Harper, C. W.

Harrington, E. T.
Hassett, D. D.
Hatfield, Margaret E.
Haug, J. F.
Haugh, J. J.
Haukohl, R. S.
Haushalter, H. P.
Haushalter, L. E.
Hausmann, P. F.
Hayes, D. M.
Headlee, C. R.
Heeb, H. J.
Hefke, H. W.
Heidner, F. C.
Heifetz, E. C.
Heil, J. V.
Heipp, E. A.
Heise, H. A.
Heller, T. A.
Henes, Edwin, Jr.
Heraty, J. A.
Hermann, A. H.
Herner, W. L.
Hertel, A. J.
Herzog, J. V.
Higgins, S. G.
High, H. C., Jr.
Hiller, R. I.
Hiller, S. J.
Hipke, G. A.
Hipke, L. W.
Hipke, M. M.
Hirschboeck, J. S.
Hirsh, L. H.
Hitz, J. B.
Hoermann, B. A.
Hofmeister, F. J.
Holbrook, A. A.
Holbrook, A. T.
Hollenbeck, S. W.
Holm, A. G.
Houghton, W. J.
Hovis, W. F., Jr.
Howard, T. J.
Huber, H. H.
Hughson, D. T.
Hultman, C. A.
Hume, W. W.
Hurley, J. R.
Hurwitz, S. P.
Huston, E. S.
Huston, John
Huth, E. P.
Hyslop, V. B.
Imp, J. F.
Irwin, R. S.
Jaastad, L. B.
Jackson, Edward
Jacobson, E. B.
Jacobson, F. J.
Jahn, R. P.
James, L. J.
Jameson, Jane
Jefferson, R. A.
Jekel, J. M.
Jelenchick, E. J.
Jenk, L. F.
Jenner, J. A.
Jermain, W. M.
Jochimsen, M. A.
Johnson, A. W.
Johnson, Frances
Johnson, H. W.
Johnson, J. A.
Johnson, J. H.
Johnston, T. L.
Joseph, W. A.
Judge, T. A.
Junck, J. A.
Jurgens, G. H.
Jurishica, A. J.
Kagen, Louis
Kah, W. W.
Kalb, C. H.
Kane, A. M.
Karen, Robert
Karr, J. K.
Kassowitz, K. E.
Kastner, A. L.
Kaufman, K. K.
Kaufman, L. W.
Kay, E. M.
Kearns, W. M.
Keating, J. L.
Kelly, G. F.
Kendall, T. E.
Kettelhut, E. J.
Kiefer, E. J.
Killan, A. D.
Kilkenny, G. S.
King, J. J.
King, J. M.
Kissling, A. C.
Kissling, A. C., Jr.
Klein, J. T.
Kleis, W. J.
Klieger, J. A.
Kline, C. L.
Klopf, H. M.
Klumb, M. G.
Knudson, A. H.
Knutson, D. L.
Koch, M. J.
Kocovsky, E. C.
Kohler, S. H.
Kohn, S. E.
Kores, Vernon
Kovacs, Arthur
Kozina, F. J.
Kozina, V. J.
Kramoris, F. H.
Kreissl, L. J., Jr.
Krembs, M. A.
Kretchmar, J. S.
Kretchmar, L. H.
Kretchmar, Morris
Kretlow, F. A.
Kreuter, G. C.
Kristjanson, H. T.
Kritter, F. J.
Kriz-Hettwer, Rose
Krueger, F. J.
Krumbiegel, E. R.
Krumenacher, F. P.
Kruszewski, J. L.
Krygier, A. J.
Krygier, W. L.
Krzysko, S. L.
Kuhn, H. J.
Kuhn, M. J.
Kult, A. S.
Kustermann, A. F.
Kwapy, C. R.
La Bissoniere, P. G.
Lademan, O. E.
Ladewig, A. W.
Ladewig, H. C.
Lando, D. H., Sr.
Lando, D. H., Jr.
Lang, V. F.
Langjahr, A. R.
La Susa, T. J.
Leach, J. E.
Lee, H. J.
Lee, P. A.
Leitch, G. W.
Lettenberger, Joseph
Levin, A. J.
Levin, J. D.
Levine, Abram
Lewis, Marian
Liebman, Albert
Light, George
Lillie, R. H.
Lindert, M. C. F.
Lobedan, E. T.
Long, C. W.
Lotz, Oscar
Lungmus, B. A.
Lustok, M. J.
Maas, D. W.
Mackoy, F. W.
Madison, F. W.
Madison, J. D
Majewski, J. T.
Malloy, T. G.
Malnekoff, B. J.
Mann, R. W.
Marck, Abraham
Margoles, F. C.
Margoles, Milton
Marks, J. L.
Markson, J. W.
Markson, L. S.
Markson, S. M.
Marlewski, C. R.
Marquardt, C. R.
Martens, E. W.
Martin, A. G.
Martineau, E. L.
Mason, E. W.
Maxwell, H. P.
Maxwell, J. W.
Maxwell, N. G.
Mayer, H. H.
McBeath, N. E.
McCabe, John
McCabe, J. O.
McCann, Edith
McCarty, R. T.
McCormick, T. F.
McDonald, C. F.
McDonald, J. F.
McDonald, R. E.
McElligott, J. A.
McKittrick, N. W.
McMahon, F. B.
McMahon, H. O.
McNamara, L. V.
McNary, J. F.
Melamed, Abraham
Mellencamp, F. J.
Meloy, G. E.
Mendeloff, Hyman
Mensing, E. H.
Merten, A. N. E.
Messmer, Clemens
Meyer, J. M.
Mikolajezak, N. A.
Millen, F. J.
Miller, E. W.
Miller, H. L.
Miller, J. P.
Miller, L. E.
Millington, P. E.
Miner, D. L.
Miner, H. B.
Moel, Morris
Molsberry, J. M.
Monroe, M. W.
Montgomery, Alexander
Montgomery, R. P.
Mookerjee, M. K.
Moore, G. E.
Morgan, J. E.
Morgan, S. F.
Morter, H. V.
Morter, R. E.
Morton, S. A.
Mountain, D. C.
Muehlhaus, F. R.
Mueller, Nina T.
Muenzer, R. J.
Mufson, J. A.
Multhauf, C. J.
Murphy, F. D.
Murphy, J. A.
Murphy, T. R.
Murphy, W. J.
Muskat, Irving
Narodick, B. G.
Natenshon, A. L.
Neacy, C. F.
Nebel, Harold
Nichols, C. H.
Niland, P. J.
Nimz, F. N.
Nimz, R. A.
Northey, T. M.
Oberbreckling, P. E.
O'Connell, J. R.
O'Connor, R. D.
O'Hara, J. J.
Ohrenstein, I. R.
O'Leary, E. B.
Olsen, A. H.
Olsen, Maurice
O'Malley, R. J.
O'Malley, T. S.
O'Malley, W. P.
O'Neill, E. J.
Orban, L. C.
Osher, N. W.
Oswald, Frederick
Ottenstein, H. H.
Otto, Owen
Ovitt, D. W.
Owen, G. C.
Owen, J. D.
Owens, A. J.
Oxman, E. M.
Ozonoff, J. B.
Palese, J. A.
Pallasch, F. J.
Panetti, H. E.
Paquette, L. J
Paulbeck, T. M.
Pedersen, Elaine K.
Peelen, A. W
Perlson, P. H.
Pessin, S. B.
Peterman, M. G.
Peters, B. J.
Peters, L. M.
Peterson, F. N.
Pfeffer, E. N.
Pfeifer, W. M.
Phillips, W. S.
Pink, J. J.
Pisciotta, A. V.
Pleyte, A. A.
Pohle, H. W.
Polacheck, W. S.
Pollack, S. K.
Popp, Albert
Powers, H. W.
Presti, A. A.
Prudowsky, H. H.
Pugh, G. J.
Purtell, P. J.
Purtell, R. F.
Quick, A. J.
Quick, E. W.
Rabin, Allen
Raine, Forrester
Ramlow, L. W.
Rand, Harold
Rank, R. T.
Ravitz, L. A.
Raymond, A. J.
Regan, J. M.
Regan, J. R.
Reifenrath, I. B.
Reinke, C. C.
Rettig, E. H.
Reuter, M. J.
Rheineck, A. F.
Ricciardi, I. J.
Rice, E. L.
Rice, R. L.
Riehl, F. W.
Rife, C. S.
Rikkers, D. F.
Ritchie, Gorton
Ritter, J. W.
Robbins, J. M.
Robbins, L. S.
Roby, H. S.
Rogers, E. H.
Rogers, M. F.
Rolfs, T. H.
Roncke, G. J.
Rose, Mona
Rosenbaum, F. F.
Rosenbaum, M. K.
Rosenberg, S. W.
Rosenberger, A. I.
Rosenthal, Samuel
Ross, F. A.
Rothman, L. E.
Rotter, E. J.
Rowlands, O. B.
Royce, Owen, Jr.
Ruch, D. M.
Rueth, J. E.
Ruppa, Rex
Ruppenthal, A. J.
Ruskin, B. A.
Russell, R. J. M.
Ryan, P. W.
Ryan, W. A.
Sadoff, H. B.
Sagi, J. H.
Sakaguchi, Shimpei
Saketos, T. P.
Salinko, S. S.
Salinsky, L. V.
Sander, O. A.
Sanfelippo, A. J.
Santer, D. G.
Santilli, M. A.
Sargent, J. C.
Sargent, J. W.
Sass, L. C.
Sauter, K. E.
Schacht, W. J
Schaeffer, B. S.
Schalmo, E. H., Jr.
Schelble, E. J.
Schelble, J. P.
Schlaepfer, Karl
Schlomovitz, B. H.
Schlomovitz, E. H.
Schlomovitz, H. H.
Schmidt, A. C.
Schmidt, C. E.
Schmidt, C. H.
Schmidt, E. C.
Schmidt, E. J.
Schmidt, H. G.
Schmit, Felix
Schmit, Louis
Schmitz, J. T.
Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
Schneider, C. R.
Schneider, C. S.
Schoenkerman, B. B.
Scholter, E. A. W.
Schowalter, R. P.
Schreiber, Manual
Schroeder, C. M.

Schroeder, H. T.
Schubert, F. J.
Schuenzel, L. G.
Schuler, F. X.
Schulz, Irwin
Schumacher, H. S.
Schumm, H. C.
Schutte, A. G.
Schwab, R. L.
Schwade, E. D.
Schwade, L. J.
Schwartz, A. B.
Schwartz, S. F.
Schweiger, L. R.
Schweitzer, G. J.
Schweitzer, W. A.
Seefeld, P. H.
Seegers, F. W.
Seelman, A. G.
Seelman, J. J.
Selle, F. S.
Seng, W. L.
Sengpil, G. W.
Senn, Ulrich
Sennett, L. W.
Servis, L. T.
Shaiken, Joseph
Shanberge, J. N.
Shaner, G. O.
Shutkin, M. W.
Shutter, H. W.
Silbar, S. J.
Silber, E. N.
Sinsky, J. E.
Slomovitz, Zachary
Slotnik, I. L.
Slutzky, Nathan
Smigielski, K. M.
Smith, J. W.
Smith, L. D.
Smuckler, R. H.
Snartemo, R. J.
Solberg, M. E.
Spear, H. Gladys
Spitz, M. M.
Spooner, A. D.
Sproule, R. P.
Squier, T. L.
Stamm, L. P.
Stark, R. M.
Steele, J. D., Jr.
Stefanez, J. S.
Steiner, C M
Stemper, J. A.
Stockinger, R. E.
Stoddard, F. J
Stollenwerk, K. J.
Stone, J. R.
Stratton, F. A.
Straus, G. D.
Studley, W. H.
Stuhler, J. D.
Sulek, A. E.
Sullivan, J. M.
Sverdlin, A. A.
Swartz, L. W.
Sweet, S. J.
Szilagyi, M. J.
Szymarek, J. E.
Tabachnick, Harry
Tacke, A. W.
Tax, A. H.
Taxman, J. E.
Tegtmeyer, G. F.
Teigland, J. D.
Teitgen, R. E.
Temple, J. W.
Terry, J. W.
Tessier, A. F.
Tharinger, E. L.
Thatcher, D. S.
Thoma, J. W.
Thomas, C. O.
Thomas, Elaine M.
Thomas, W. D.
Thompson, R. D.
Thorstensen, A. H.
Thranow, J. A.
Thurwachter, L. F., Jr.
Toenhart, O. E.
Tolan, T. L.
Torcivia, S. S.
Trangsrud, H. A.
Treskow, F. G.
Trimborn, B. A.
Tuft, W. R.
Tufts, Millard
Turney, C. F
Twelmeyer, H. F.
Urdan, B. E.
Usow, E. J.
Usow, J. M.
Uszler, L. B.
Vaccaro, J. E.
Van Hecke, L. J.
Veit, Henry
Verch, L. H.
Verdone, A. J.
Wade, Chester
Wagner, Marvin
Wagner, P. C.
Waisbren, B. A.
Waisman, R. C.
Waldeck, E. A.
Walker, L. J.
Walton, W. B.
Warner, R. C.
Warschauer, Bruno
Warth, C. G.
Washburn, R. G.
Watts, Alice D.
Waxman, S. I.
Weber, A. J.
Weber, J. E.
Wegmann, G. H.
Wegmann, N. J.
Weil, H. R.
Weingart, W. F.
Weinshel, L. R.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, L. A.
Weisfeldt, S. C.
Wells, Marvin
Welsch, R. G.
Welsh, E. C.
Wendt, W. P.
Wepfer, J. F.
Werba, D. R.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Whitaker, P. J.
Wiener, Kurt
Wiese, M. E. J.
Wiesen, R. P.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
Witte, D. H.
Wolter, S. H.
Wolters, H. F.
Wong, V. J.
Wright, H. H.
Wyland, J. S.
Wyman, J. F.
Wynn, S. K.
Yaffe, Aaron
Young, A. F.
Yunck, R. E.
Zahl, W. H.
Zaun, J. J., Jr.
Zawodny, S. E.
Ziegler, C. T.
Zillmer, Helen J.
Zimmermann, B. M.
Zmyslony, W. P.
Zubatsky, D. J.
Zurheide, H. O.

Mineral Point:
Hamlin, W. D.
Ludden, H. D.
White, C. L.

Minocqua:
Huber, G. W.
Sprague, J. P.

Mondovi:
Gillette, F. J.
Johnson, B. F.
Meyer, C. F.
Sharp, D. S.
Walker, J. P.

Monroe:
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Blum, O. S.
Brunkow, B. H
Eckstam, E. E.
Fencil, W. J.
Gnagi, W. B., Jr.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Mings, D. E
Moore, L. A.
Peters, E. E.
Ruehlman, D. D.
Schindler, J. A.
Snowden, P. W.
Weir, J. R.
Witte, K. B.

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Rasmussen, N. G.

Monticello:
Benkendorf, Charles

Montreal:
Baird, H. D.
Pierpont, J. M.

Mosince:
Hoessel, A. W.
Knoedler, W. A., Jr.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Buckner, H. M.
Morrison, M. T.

Mukwonago:
Kern, E. E.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Henning, Laura E.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Smith, F. H.
Smith, Robin
Smith, T. D.
Springer, V. G.
Strauser, E. R.

Neillsville:
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.

Nekoosa:
Jaffee, M. L.

New Auburn:
Stang, H. M.

Newburg:
Salter, R. K.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J.
Hicks, E. V.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Ferguson, S. H.
Weston, C. L.

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.

Niagara:
Lamb, R. F.
McCormack, E. A.

North Lake:
Donnelly, F. J.

Norwalk:
Allen, J. S.

Oconomowoc:
Feasler, C. H.
James, W. D.
Lohrman, G. H.
Loughnan, A. J.
Love, G. R.
Matt, J. R.
Rogers, A. F.
Stemper, Irene T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.
Wilkinson, P. M.

Oconto:
Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:
Goggins, R. J.
Rauchschwalbe, L. E.
Robinson, T. N.

Ogema:
Rinehart, B. M.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Ontario:
Devine, G. C.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Beatty, S. R.
Behnke, C. H.
Bitter, R. H.
Brei, F. A.
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haseltine, C. P.
Haubrick, H. J.
Helmes, L. O.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Lelbenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Meilicke, C. A.
Meli, J. V.
Meusel, H. H
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Steele, G. A.
Steen, M. H.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.

Osseo:
Knutson, Oscar
Leasum, R. N.

Owen:
Koch, J. W.

Oxford:
Nafziger, E. G.

Pardeeville:
Winkler, H. A.

Park Falls:
Leahy, J. D.
Leahy, J. J.
Murphy, J. L.

Pepin:
Belitz, A. E.

Peshtigo:
Grindrod, J. M.
Haasl, H. W.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phelps:
Schmitt, R. W.

Phillips:
Niebauer, W. E.
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Platteville:
Andrew, C. H.
Bair, G. W.
Conklin, J. W.
Cunningham, Wilson
Doeringsfeld, H. L.
Moffett, J. L.
Soles, F. A.

Plum City:
Steiger, E. E.

Plymouth:
Brickbauer, A. J.
Deicher, H. F.
Ditsch, L. C.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Van Ells, L. A.
Weisse, H. A.

Portage:
Harkins, J. P.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Edwards:
Backus, O. A.

Port Washington:
Barr, A. H.
Kauth, C. P.
Savage, G. F.
Stein, C. C.

Potosi:
Kelly, W. J.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Konicek, R. G.
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Trautmann, Milton
Zauft, G. F.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.
Theiler, A. C.

Pulaski:
Brusky, S. F.
Shippy, V. J.

Racine:
Albino, J. M.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Buckley, W. E.
Burch, V. J.
Caton, J. R.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Docter, J. C.
Dunham, C. T.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Gillett, G. N.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jamieson, J. G.
Jones, Beatrice O.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lehner, R. H.
Lifschutz, L. M.
Lindner, A. M.
Little, W. J.
Low, N. L.
MacVicar, E. L., Jr.
Madden, W. J.
Marek, F. B.
Mayer, R. J.
Miller, H. C.
Nickelsen, J. R.
Olson, E. S.
Peterson, R. O.
Pfeifer, E. C.
Pfeiffer, O. W.
Pitts, Eugene
Pope, F. W.
Postorino, J. D.
Rodick, J. C.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Schenkenberg, Grace E.
Schleper, A. J.
Schneller, E. J.
Schuster, Myron
Skow, G. D.
Smullen, G. H.
Steffen, Elizabeth A.
von Buddenbrock, Erick
von Jarchow, B. L.
Walter, G. W.
Walters, H. G.
Wier, F. A.
Woods, E. W.
Wright, R. S.

Randolph:
Horvath, D. C.
Jones, A. W.

Random Lake:
Russell, J. A.

Reedsburg:
Booker, J. A.
Hanko, J. E.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.

Reedsville:
Cary, E. C.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Gager, W. F.
Harter, A. F.
Komasinski, V. W.
Osborne, R. R.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Eidsmoe, N. A.
Johnson, A. G.
MacMillan, D. G.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.
Vaudreuil, W. F.

Richfield:
Kern, T. J.

Richland Center:
Edwards, W. C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Maas, W. C.

Ripon:
Bachus, A. C.
Barnes, E. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
O'Neal, Orvil
Schuler, W. H.
Watson, E. L.

River Falls:
Cairns, R. U.
Davee, Chalmer
Gutzler, P. H.

Roberts:
Ford, A. M.

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Riegel, F. B.
Riegel, J. A.

Sauk City:
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

Sawyer:
Olsen, W. J.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Christofferson, J. W.
Hardgrove, J. H.
Henke, F. W.
Marsh, H. C.
Peterson, L. W.
Rivard, R. R.
Schutz, W. J.
Sebesta, A. J.

Sheboygan:
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Cinelis, Ann
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
Gruenwald, Ludwig
Gunther, T. J.
Heiden, H. H.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Hougen, E. T.
Hulbregtse, W. G.
Juckem, G. J.
Keane, K. M.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.

Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Schmitt, A. J.
Schott, E. G.
Schroeder, I. L.
Simonson, L. M.
Simpson, R. M.
Squire, C. A.
Tasche, C. T.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Winsauer, H. J.
Wood, R. A.
Zaegel, R. L.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Pfeiler, A. G.

Shell Lake:
Moen, D. V.

Shiocton:
LaCroix, G. M.

Shullsburg:
Garland, D. J.
Gratiot, Mary P.

Silver Lake:
De Witt, C. A.

Siren:
Grindall, G. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

Solon Springs:
Wilcox, A. G.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Grimm, J. J.
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Rumph, C. L.

Sparta:
Beebe, D. C.
Beebe, S. D
Harris, A. J.
Lukasek, E. O.
Mannis, Harry
Scantleton, J. M
Van Susteren, J. A.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

Spooner:
Olson, L. J.
Sahs, M. H.

Spring Valley:
Hill, E. F.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

Statesan:
Nichols, G. P.
Pummer, L. R.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Cowan, W. F.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kidder, E. E.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Sanders, R. H.
Sheehan, W. C.
Slater, R. H.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Nordholm, V. W.
Peterson, R. K.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Strum:
Peterson, D. R.

Sturgeon Bay:
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.
Peters, H. R.
Pinney, J. C
Sheets, W. G.
Sweeney, J. D.

Sturtevant:
Peehn, F. G.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.

Superior:
Anderson, R. T.
Beebe, L. W.
Carpenter, E. E.
Christianson, H. B.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Kyllo, J. C.
Lavine, M. M.
McGill, J. W.
Perrin, S. H.
Picard, C. J.
Reibold, F. W.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Dougherty, J. S.
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.
Langenfeld, P. F.

Thiensville:
Elbe, T. D.
Scholz, H. F.
Scheunemann, W. E.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Tigerton:
Heise, L. F.
Rogers, R. M.

Tomah:
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Scheurich, L. G.
Winter, A. E.

Tomahawk:
Baker, G. R.
Baker, R. G.
Jarvis, D. F.
McCormick, W. C.

Two Rivers:
Kozelka, A. W.
Kuljis, D. A.
Marshall, W. S.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W.
Schulz, G. J.

Valders:
Huth, E. W.

Verona:
Weiland, H. P.

Viola:
Meboe, Joseph

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Hirsch, R. S.
Keith-Swenson, S. A.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O. S.

Walworth:
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Bultema, J. H.
Dietz, R. J.

Waterloo:
Allen, S. C.
Kennedy, F. H.
Schmidt, C. W.

Watertown:
Brazos, J. C.
Burzynski, E. E.
Dierker, O. F.
Hahn, A. C.
Haney, F. C.
Kosanke, F. E.
Miller, E. A.
Nowack, L. H.
Nowack, L. W.
Welbourne, R. P.
Zimmerman, F. H.

Waukesha:
Bartos, J. A.
Bolger, James V., Jr.
Brown, W. E.
Campbell, P. E.
Campbell, W. B.
Clark, O. C.
Dangle, H. C.
Davies, E. B.
Davies, Gwilym
Edmondson, C. C.
Frick, J. C.
Gantz, H. A.
Grosskopf, E. C.
Houston, H. S.
Merkow, William
Promer, J. E.
Scheele, F. M.
Settlage, H. A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Werra, M. J.
Williams, A. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Bowman, F. F.
Jackson, J. A.
Marquis, W. R.

Waupaca:
Boudry, M. O.
Breckenridge, H. E.
Christofferson, A. M.
Patterson, L. G.
Salan, Sam
Steiner, J. H.

Waupun:
Hebenstreit, A. J.
Hull, H. H.
Klepfer, J. F.
Petters, W. J.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Semmens, J. P.
Wagner, W. A.

Wausau:
Becker, W. T.
Brick, E. B.
Brodhead, R. H.
Burek, A. W.
Christensen, H. W.
Davis, Helen Crawford
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Fleming, N. E.
Flemming, E. E.
Foerster, J. M.
Freeman, J. M.
Green, D. M.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Jackson, J. A.
Jones, M. L.
Kelley, O. R.
Larsen, R. B.
Ludwig, E. P.
McCandless, E. E.
Miller, W. C.
Podruch, P. E.
Prehn, F. C.
Schroth, G. J.
Shannon, R. C.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Trumbo, J. K.
Wilson, O. M.
Yoran, C. M.
Zagaria, J. F.

Wautoma:
Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.
Wright, C. A.

Wauwatosa:
Banyal, A. L.
Beck, K. H.
Beffel, J. M.
Brand, W. D.
Brussock, W. A.
Burgardt, G. F.
Cadden, A. V.
Daniels, E. R.
Danziger, Lewis
Dettmann, N. F.
Deysach, L. J.
Donath, L. H.
Engstrom, W. W.
Fifrick, L. L.
Giesen, Charles P.
Glienke, C. F.
Kasak, Michael
Kehlnhofer, F. H.
Kindwall, J. A.

Klopfer, W. P.
Kocovsky, C. J.
Kradwell, W. T.
Krill, R. J.
Kuzma, J. F.
Liefert, K. A.
Leitschuh, R. B.
McCormick, G. E.
Menes, T. F.
Morrison, R. C.
Osgood, C. W
Pendergast, T. J.
Rastetter, J. W.
Rettig, F. E.
Sargeant, H. W.
Schoene, F. C.
Seifert, K. A.
Seymer, L. A.
Truitt, J. W.
Winters, K. J.
Worm, G. J.

Webster:
Maas, D. A.

West Allis:
Brumbaugh, E. V.
Collins, E. G.
Couch, T. T.
Dohearty, W. H.
Everts, E. L.
Frederick, R. H.
Fulton, J. W.
Hanley, W. J.
Heinan, F. C.
Hermann, W. C.
Hugo, G. J.
Malensek, M. C.
Nefches, M. S.
Ohlsen, M. P.
Olmstead, E. G.
Olson, C. R.
Smits, R. H.
Stamm, M. P.
Steckler, Armin
Stern, C. S.
Stern, L. S.
Toepfer, R. A.
Tordoff, J. J.
Wilkinson, E. D.
Wilkinson, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F.
Bernhardt, E. L.
Bush, F. I.
Driessel, R. H.
Driessel, S. J.
Frankow, R. O.
Grundahl, A. T.
Heidner, A. H.
Kauth, P. M.
Koehler, J. P.
Nielsen, W. A.
Pick, J. W.

Westby:
Bland, P. T.
Strand, C. M.

West DePere:
Lenz, R. B.

Westfield:
Fredrick, H. Y.

West Salem:
Goedecke, R. H.
Wakefield, G. F.

Weyauwega:
Weller, E. A.

Whitehall:
MacCornack, R. L.
Simons, N. S
Simonson, S. W.
Tyvand, J. C.

Whitelaw:
Gutheil, D. A.

Whitewater:
Ambrose, S. H.
Meighan, P. P.
Miller, R. H.

Wild Rose:
Hadden, Shirley L.
Hong, Roy

Williams Bay:
Wiswell, C. Y.

Winnebago:
Braun, R. F.
Murphy, J. H.
Perssion, L. B.
Petersik, J. T.
Thackeray, R. C.

Wisconsin Dells:
Broderick, C. F.
Ellenz, G. B.
Gissal, F. W.
Houghton, J. H.

Wisconsin Rapids:
Barnet, E. G.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Nelson, W. L.
Pomainville, F. X.
Pomainville, H. G.
Pomainville, L. C.
Waters, Donald

Withee:
Johnson, J. W.

Wittenberg:
Olson, M. H.

Wonewoc:
Baker, H. P.

Wood:
Bullock, A. A., Jr.
Dessel, B. H.
Guckien, J. L.
Jones, L. E.
Lehman, R. H.
Levin, J. J.
Liefert, W. C.
Lubitz, J. M.
Macht, A. J.
Morrison, Thomas
O'Connell, R. A.
Ogilvie, O. E.
Pfeffer, T. J.
Piaskoski, R. G.
Plank, L. E.
Schwarz, R. J.
Siegrist, K. J.
Spencer, G. N.

Woodruff:
Newcomb, Kate P.

Wrightstown:
Vande Loo, F. B

Wyocena:
de Neveu, A. V.

Members Serving in the Armed Forces

Altman, J. S. ----------Great Lakes, Illinois
Balliet, C. M. ----------Wausau, Wisconsin
Becker, D. B., Jr. ----------New York City, New York
Bennett, J. C. ----------Burlington, Wisconsin
Beno, T. J. ----------Fort Riley, Kansas
Bowden, R. H.
------Francis E. Warren Air Force Base, Wyoming
Brandt, E. F. ----------Wood, Wisconsin
Buffmire, D. K. ----------Camp McCoy, Wisconsin
Caskey, H. S. ----------Sumter, South Carolina
Couch, J. R. ----------San Antonio, Texas
Crepea, S. B.----------Geneva, New York
Davis, N. S., Jr.----------Sister Bay, Wisconsin
Dedinsky, G. A. ----------Smock, Pennsylvania
Enneking, W. F. ----------Stevens Point, Wisconsin
Flynn, R. A. ----------Camp McCoy, Wisconsin
Fox, G. E. ----------New York City, New York
Frisch, J. G. ----------Randolph, Texas
Frye, J. W. ----------San Francisco, California
Gage, R. G. ----------Kimberly, Wisconsin
Gerth, R. E. ----------Oshkosh, Wisconsin
Gettelman, S. T. ----------Fort Riley, Kansas
Grubb, K. P., Jr. ----------Great Lakes, Illinois
Hartenstein, Hans ----------Milwaukee, Wisconsin
Haug, T. M. ----------Rhinelander, Wisconsin
Hoffman, W. K. ----------Camp Rucker, Alabama
Hohler, E. J. ----------San Antonio, Texas
Hotter, J. T. ----------West Allis, Wisconsin
Hovda, A. A. ----------Tomah, Wisconsin
Huston, John, Jr. ----------Milwaukee, Wisconsin
Jarvis, E. C. ----------Minneapolis, Minnesota
Jeffries, D. A. ----------Granite City, Illinois
Jensen, R. E. ----------Waukegan, Illinois
Junkerman, C. L. ----------Yokosuka, Japan
Kanin, H. J. ----------San Antonio, Texas
Kelble, J. A. ----------Milwaukee, Wisconsin
Keller, L. W. ----------Seattle, Washington
Kelly, C. M., Jr. ----------Sanoma, California
Kinsey, J. L. ----------New London, Connecticut
Knight, R. G. ----------San Francisco, California
Koepsell, J. E. ----------Fort Custer, Michigan
Kohn, A. M. ----------Sewart, Tennessee
Kozokoff, N. J. ----------San Antonio, Texas
Larkey, J. A. ----------Milwaukee, Wisconsin
Lawler, P. J. ----------Milwaukee, Wisconsin
Leiser, A. E. ----------Monroe, Wisconsin
Lindemann, C. E. ----------Camp McCoy, Wisconsin
Lohr, W. H. ----------Fort Lawton, Washington
Marks, J. A. ----------New York City, New York
McCreary, W. K. ----------Buckley Field, Colorado
McCullough, John C. ----------Fond du Lac, Wisconsin
McIntosh, J. F. ----------Madison, Wisconsin
McLaughlin, B. C. ----------Milwaukee, Wisconsin
McLeod, J. J., Jr. ----------Great Lakes, Illinois
Means, J. A. ----------Rolla, Missouri
Mendez, R. G. ----------Chicago, Illinois
Merdinger, W. F., Jr. ----------Milwaukee, Wisconsin
Mickle, K. C. ----------Fort Leonard Wood, Missouri
Mitz, Morris ----------Falmouth, Massachusetts
Nelson, M. W. ------Chanute Air Force Base, Illinois
Olinger, J. K. ----------Camp Cook, California
Otterholt, E. R. ----------Janesville, Wisconsin
Pierson, P. S. ----------Milwaukee, Wisconsin
Pranke, D. W. ----------Beloit, Wisconsin
Price, D. J. ----------South Milwaukee, Wisconsin
Puchner, T. C. ----------Cherry Point, North Carolina
Pulito, F. J. ----------San Diego, California
Ragaz, F. J. B. ----------Madison, Wisconsin
Russell, W. T. ----------Chamblee, Georgia
Sattler, M. E. ----------Amarillo, Texas
Savory, P. B. ----------Tacoma, Washington
Schaefer, H. E. ----------Randolph, Texas
Scheller, R. F. ----------San Antonio, Texas
Schlenker, L. T. ----------Fort Ord, California
Schmidt, R. E. ----------Smyrna, Tennessee
Schmitt, G. D.--Mountain Home Air Force Base, Idaho
Schroeder, R. W. ----------Fond du Lac, Wisconsin
Schultz, A. E. ----------Victorville, California
Schuyler, R. M. ----------Milwaukee, Wisconsin
Seno, Elvira C. ----------Waukesha, Wisconsin
Silbar, J. D. ----------Camp Atterbury, Indiana
Sinnett, J. M. ----------Pensacola, Florida
Slomowitz, Jonathan ----------Milwaukee, Wisconsin
Sroka, W. C. ----------Enid, Oklahoma
Stokke, O. H. ----------Milwaukee, Wisconsin
Taniguchi, Tokuso ----------Seattle, Washington
Teplin, Ervin ----------Washington, D. C.
Thiede, W. H. ----------Milwaukee, Wisconsin
VanLiere, J. D. ----------Wichita Falls, Texas
Walsh, J. F. ----------San Francisco, California
Webb, W. C. ------Maxwell Air Force Base, Alabama
Weber, M. L. ----------Milwaukee, Wisconsin
Williamson, W. H. ----------San Francisco, California
Wolf, L. P. ----------Milwaukee, Wisconsin
Worobec, R. N. ----------Fort Belvoir, Virginia

Out-of-State Members

Anderson, N. P. ---------- Crystal River, Florida
Archer, W. E. ---------- Anoka, Minnesota

Barnes, J. S. ---------- Albuquerque, New Mexico
Baum, E. L. ---------- Naples, Florida
Becker, W. C. ---------- Dublin, Georgia
Bleyer, L. F. ---------- Providence, Rhode Island
Brown, W. F. ---------- Rosendale, Massachusetts
Bruns, D. H. ---------- Camarillo, California
Buesseler, J. A. ---------- Springfield, Ohio
Buhl, T. L. ---------- Los Angeles, California

Coffin, L. E. ---------- Tucson, Arizona
Cofrin, D. A. ---------- Green Bay, Wisconsin
Creasy, L. E. ---------- St. Petersburg, Florida
Cunningham, R. T. ---------- Bakersfield, California

Dredge, T. J. ---------- Yankton, South Dakota
Dunn, E. T. ---------- Clifton Forge, Virginia

Eidam, L. W. ---------- Santa Barbara, California
Eisele, P. L. ---------- Springfield, Missouri
Eisen, H. L. ---------- Ontario, California
Engels, D. H. ---------- Huntington, West Virginia
Epperson, K. D. ---------- Chicago, Illinois

Feurig, J. S. ---------- Columbia, Missouri
Fogelberg, Alma ---------- Chevy Chase, Maryland

Glasson, L. G. G. ---------- Miami, Florida
Grant, L. C., Jr. ---------- New York City, New York
Gross, T. A. ---------- Nashville, Tennessee
Gulbrandsen, Halbert ---------- Denver, Colorado

Haley, H. B. ---------- Boston, Massachusetts
Hastings, E. V. ---------- Augusta, Georgia
Henry, E. W. ---------- Camarillo, California
Hoffmann, G. T. ---------- Galveston, Texas
Horwich, Harry ---------- New York City, New York
Howard, M. Q. ---------- Blackfoot, Idaho
Hoyme, Gjermund ---------- Coronado, California

Ingersoll, B. P. ---------- Meridian, Mississippi
Irwin, H. J. ---------- Pecatonica, Illinois

Jacks, R. R. ---------- Menard, Illinois
Jackson, R. C. ---------- Rochester, Minnesota
Johnson, H. C. ---------- Eugene, Oregon
Johnson, R. D. ---------- Ann Arbor, Michigan
Juhl, J. H. ---------- Minneapolis, Minnesota

Kabler, J. D. ---------- Wichita, Kansas
Kersting, D. W. ---------- Bethesda, Maryland
Kilkenny, T. E. ---------- New Orleans, Louisiana
Korducki, S. A. ---------- Cleveland, Ohio
Kriz, G. A. ---------- Phoenix, Arizona

Lamal, A. H. ---------- Watford City, North Dakota
Lehmer, R. A. ---------- Champaign, Illinois
LeTellier, M. S. ---------- Astoria, Oregon
Lukes, R. E. ---------- Washington, D. C.

MacKay, A. M. ---------- Redwood City, California
Malloy, D. J. ---------- Hines, Illinois
Mathewson, R. C. ---------- New Orleans, Louisiana
Matthiesen, D. E. ---------- Memphis, Tennessee
Mazzitello, W. F. ---------- St. Paul, Minnesota
Megna, Salvatore ---------- Tucson, Arizona
Moore, J. C. ---------- Los Angeles, California
Mudge, W. A., Jr. ---------- Hines, Illinois
Mullen, R. A. ---------- Tampa, Florida
Muscato, G. V., Jr. ---------- Lockport, New York

Nelson, P. D. ---------- Norwich, Connecticut
Nicolai, C. H. ---------- St. Louis, Missouri
Nissenbaum, James ---------- Fort Wayne, Indiana

O'Donnell, Mae J. ---------- Wadsworth, Kansas
Olson, H. J. ---------- Los Angeles, California

Paulson, J. F. ---------- Mason City, Iowa
Peabody, C. S. ---------- Youngstown, Ohio

Quinn, R. W. ---------- Nashville, Tennessee

Rasmussen, A. F., Jr. ---------- Los Angeles, California
Redlin, R. R. ---------- Corona, California
Rice, E. M. ---------- Alta Vista, California
Riegel, G. S. ---------- St. Paul, Minnesota

Sanders, D. D. ---------- Long Beach, California
Schubert, E. F. ---------- Logansport, Indiana
Searle, D. R. ---------- Safety Harbor, Florida
Shimpa, J. F. ---------- Cheyenne, Wyoming
Sims, A. M. ---------- Encino, California
Sitterson, B. W. ---------- Mariemont, Ohio
Sprecher, H. C. ---------- Chicago, Illinois
Stehlin, J. S. ---------- Boston, Massachusetts
Still, R. P. ---------- DeKalb, Illinois
Sundquist, G. V. ---------- Cheyenne, Wyoming
Sweeney, J. E. ---------- Fargo, North Dakota

Taylor, J. Gurney ---------- Miami, Florida
Teresi, J. L. ---------- Saratoga, California
Thanos, J. N. ---------- Campbell, Ohio
Thorngate, George III ---------- Indo-China
Tuchscherer, Mabel E. ---------- Anaconda, Montana

Van Kirk, F. W. ---------- Beverly Hills, California
Van Riper, H. E. ---------- New York City, New York

Wallner, Alfred ---------- Bakersville, California
Waters, R. M. ---------- Orlando, Florida
Wells, May R. ---------- Belleville, Illinois
Wenstrand, D. E. W. ---------- Tryon, North Carolina
White, D. H., Jr. ---------- Indianapolis, Indiana
Wierzbinski, F. A. ---------- Iowa City, Iowa
Wilson, N. M. ---------- Elmhurst, Illinois
Wood, H. W., Jr. ---------- Norfolk, Virginia

Zeier, F. G. ---------- Rockford, Illinois

Life Members of State Medical Society

Allen, W. J. ---------- Beloit

Barnes, J. S. ---------- Milwaukee
Beebe, L. W. ---------- Superior
Beebe, S. D. ---------- Sparta
Belitz, A. E. ---------- Pepin
Bolton, E. L. ---------- Appleton
Brehm, H. J. ---------- Racine
Brooks, E. H. ---------- Bloomington
Brunckhorst, F. O. ---------- Neenah

Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Caswell, H. O. ---------- Jefferson
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Cunningham, Wilson ---------- Platteville
Donohue, M. J. ---------- Antigo

Fazen, L. E. ---------- Racine
Folsom, W. H. ---------- Fond du Lac
Forkin, G. E. ---------- Menasha
Friend, L. J. ---------- Beloit

Gavin, S. E. ---------- Fond du Lac
Goggins, R. J. ---------- Oconto Falls
Grosskopf, E. C. ---------- Waukesha

Hammond, F. W. ---------- Manitowoc
Hardgrove, J. H. ---------- Shawano
Haubrick, H. J. ---------- Oshkosh
Haushalter, H. P. ---------- Milwaukee
Heraty, J. E. ---------- La Crosse
Hipke, G. A. ---------- Milwaukee

Irwin, H. J. ---------- Pecatonica, Illinois

Jackson, J. A. ---------- Wausau
Jegi, H. A. ---------- Galesville
Junck, J. A. ---------- Milwaukee

Leonard, C. W. ---------- Fond du Lac
Linn, W. N. ---------- Oshkosh
Lockhart, C. W. ---------- Mellen
Lockhart, J. W. ---------- Oshkosh
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Lundmark, L. M. ---------- Ladysmith

Marshall, V. F. ---------- Appleton
Meusel, H. H. ---------- Oshkosh
Munn, W. A. ---------- Janesville

Nadeau, A. T. ---------- Marinette
Notbohm, W. R. ---------- Dousman

Nuzum, T. W. ---------- Janesville
Olmsted, A. O. ---------- Green Bay
Peehn, F. G. ---------- Sturtevant
Peterson, C. F. ---------- Independence
Petzke, E. A. ---------- Hixton
Pomainville, F. X. ---------- Wisconsin Rapids
Pope, F. W. ---------- Racine
Quick, E. W. ---------- Milwaukee
Radloff, A. C. ---------- Plymouth
Raymond, R. G. ---------- Brownsville
Reeve, J. S. ---------- Appleton
Schein, J. E. ---------- Oshkosh
Schmidt, E. S. ---------- Green Bay
Schroeder, H. F. ---------- Marinette
Smith, S. M. B. ---------- Wausau
Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Twohig, D. J. ---------- Fond du Lac
Waters, Donald ---------- Wisconsin Rapids
Webb, E. P. ---------- Beaver Dam
Wheeler, W. P. ---------- Oshkosh
Wilkinson, M. R. ---------- Oconomowoc
Witcpalek, W. W. ---------- Kewaunee
Young, A. F. ---------- Milwaukee

Honorary Members of County and State Societies

Bradley, H. C. ---------- Madison
Clark, P. F. ---------- Madison
McCracken, R. W. ---------- Union Grove
Meek, W. J. ---------- Madison
Pusey, W. A. ---------- Chicago, Illinois
Sisk, I. R. ---------- Madison
Sullivan, W. E. ---------- Madison
Taylor, J. Gurney ---------- Miami, Fla.

SOCIAL SECURITY BENEFITS FOR DOCTORS

The income earned by a physician from his own practice or a medical partnership of which he is a member does not entitle him to Social Security benefits.

Doctors and nurses who are employed by organizations organized for profit have been covered by Social Security all along. Doctors and nurses employed by nonprofit organizations may be covered provided the employer waives its statutory exemption and two thirds of its employees sign a statement asking to be covered.

Many doctors, although now self employed, are currently covered under Social Security because of active military service at any time after September 16, 1940, or because of prior practice in the capacity of an employee of another physician. Such physicians will continue to be covered for a period after 1950, roughly equal to twice the length of time spent in military service or as an employee. For example, a physician who spent three years in active military service will be currently covered until the end of 1956 even though both before and after such service he was self employed.

If a physician dies while currently covered, his widow, so long as she has minor children under 18 years of age in her care, will be entitled to monthly survivor's benefits. Inasmuch as wage credits of $160 per month are given for military service, as contrasted with a maximum for other employment of $300 per month, the amount of the monthly benefit to the widow will not be the $168 maximum. It will however be substantial.

The physician and his wife will be entitled to old-age benefits for the balance of their lives, if the physician reaches the age of 65 years while currently covered.

A person becomes permanently insured and covered after 10 years covered work earned at any time after the original Social Security law was passed.

The amount of benefits payable was raised about 12 per cent in 1952 to conform to the increased cost of living. This affects present as well as future beneficiaries.

CHICAGO MEDICAL SOCIETY TO HOLD CLINICAL CONFERENCE MARCH 3–6

March 3, 1953, will mark the opening day of the four day annual Clinical Conference of the Chicago Medical Society. This conference is designed to be of interest to both the specialist and the general practitioner. It will be held at the Palmer House in Chicago and will present a variety of subjects setting forth the latest information available to the medical profession.

Conducting the conference will be a faculty ranging from 35 to 40 outstanding speakers, each offering a presentation relating to his specialty. In addition another group will give daily teaching demonstrations which will include the presentation of patients. They will emphasize the actual technic to be employed in handling orthopedic, medical, and pediatric problems. In addition to holding these demonstrations each day, there will be a panel discussion at a round table luncheon presenting topics of timely interest.

This is an activity of the Chicago Medical Society for its membership to whom no fee is charged. Those who are not members of the Chicago Medical Society are asked to register for the four days at the fee of $5.00. For further details, write to the Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

* As amended by the 1951 House of Delegates.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one addi-

tional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the

regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during February for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Council on Scientific Work.
- A Council on Medical Service.
- A Committee on Public Policy.
- A Committee on Grievances.
- A Committee on Medical Education and Hospitals.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Hospital Relations.
- A Committee on Cancer.

Unless otherwise provided in these By-Laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates. provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such

LIBRARY OF THE COLLEGE OF PHYSICI

postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of five members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of six members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 6. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate

of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

PRESCRIPTION OF NARCOTICS

The question has been asked whether a physician may legally write a prescription for narcotic drugs on the representation of a person other than the patient in a situation in which the physician does not know and has not actually seen the supposed patient.

The question must be answered with a strong negative. Before narcotics can be prescribed, first, the physician must know that a particular patient exists; second, he must also know, on the basis of examination and diagnosis, that the particular patient needs narcotics or a medicine containing narcotics. The recital of a person other than the patient to the physician is not enough, and the physician who prescribes narcotics for a person he does not know to exist violates the law.

Physicians are cautioned never to prescribe narcotics for a patient unless by examination and diagnosis the patient is known to exist and until a need for narcotics has been verified.

Principles of Medical Ethics of the American Medical Association

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

CHAPTER 1

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor

* Sir Thomas Watson.

profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SEC. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be consid-

* Nicon, father of Galen.

ered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

Article II.—Professional Services of Physicians to Each Other

DEPENDENCE OF PHYSICIANS ON EACH OTHER

Sec. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

Article III.—Duties of Physicians in Consultations

CONSULTATIONS SHOULD BE ENCOURAGED

Sec. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATIONS

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

Sec. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the

differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

1952–53

HEADQUARTERS OF THE ASSOCIATION, 535 N. DEARBORN ST., CHICAGO

EDWARD J. McCORMICK
President-Elect

LOUIS H. BAUER
President

G. F. LULL
Secretary and General Manager

GENERAL OFFICERS

President—LOUIS H. BAUER_____Hempstead, N. Y.
President-Elect—EDWARD J. McCORMICK _____Toledo, Ohio
Vice President—LEO F. SCHIFF__Plattsburg, N. Y.
Secretary and General Manager—GEORGE F. LULL _____Chicago
Assistant Secretary—ERNEST B. HOWARD___Chicago
Treasurer—J. J. MOORE _____Chicago
Speaker, House of Delegates—JAMES R. REULING _____Bayside, N. Y.
Vice Speaker, House of Delegates—E. VINCENT ASKEY_____Los Angeles
Editor—AUSTIN SMITH_____Chicago
Associate Editor—JOHNSON F. HAMMOND__Chicago
Business Manager—THOMAS R. GARDINER___Chicago

BOARD OF TRUSTEES

Dwight H. Murray, Chairman_____Napa, Calif.
Edwin S. Hamilton_____Kankakee, Ill.
Gunnar Gundersen_____La Crosse, Wis.
David B. Allman_____Atlantic City, N. J.
F. J. L. Blasingame_____Wharton, Texas
L. W. Larson_____Bismarck, N. D.
Thomas P. Murdock_____Meriden, Conn.
Walter B. Martin_____Norfolk, Va.
James R. McVay_____Kansas City, Mo.

JUDICIAL COUNCIL

Edward R. Cunniffe, Chairman_____New York
H. L. Pearson, Jr._____ Miami, Fla.
J. B. Lukins_____Louisville, Ky.
Louis A. Buie_____Rochester, Minn.
Walter F. Donaldson_____Pittsburgh
George F. Lull, Secretary_____Chicago

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

H. G. Weiskotten, Chairman____Skaneateles, N. Y.
Victor Johnson_____Rochester, Minn.
W. L. Pressly_____Due West, S. C.
Harvey B. Stone_____Baltimore
Guy A. Caldwell_____New Orleans
F. D. Murphy_____Lawrence, Kans.
L. S. McKittrick_____Boston
C. T. Stone, Sr._____Galveston, Texas
J. M. Faulkner_____Boston
John W. Cline_____San Francisco
Donald G. Anderson, Secretary_____Chicago

COUNCIL ON SCIENTIFIC ASSEMBLY

Henry R. Viets, Chairman_____Boston
Stanley P. Reimann_____Philadelphia
Alphonse McMahon_____St. Louis
Charles H. Phifer_____Chicago
Carl A. Lincke_____Carrollton, Ohio
Michael A. DeBakey_____Houston, Texas
Samuel P. Newman_____Denver
E. J. McCormick, ex officio_____Toledo, Ohio

COUNCIL ON MEDICAL SERVICE

Elmer Hess, Chairman_____Erie, Pa.
Jesse D. Hamer_____Phoenix, Ariz.
H. B. Mulholland_____Charlottesville, Va.
Joseph D. McCarthy_____Omaha
John W. Cline_____San Francisco
David B. Allman_____Atlantic City, N. J.
James Q. Graves_____Monroe, La.
C. E. Wertz_____Buffalo, N. Y.
Louis H. Bauer_____Hempstead, N. Y.
Thomas A. Hendricks, Secretary_____Chicago

Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

Corrective Action of Metamucil® in Abnormal Physiology of Constipation

Abnormally prolonged colonic retention, whether in a spastic or an atonic colon, demands the greatest care to assure correction.

The mucosa does not require stimulating; hence, stimulating cathartics, "roughage" and other physical and chemical irritating measures, are today often considered irrational.

On the other hand, the muscularis does require a stimulus to initiate peristalsis. This physiologic stimulus is the mechanism by which bland distention of the colon establishes a reflex, with the muscularis at the terminus of the reflex arc.

Metamucil literally reeducates the sluggish and also the spastic colon. Taken with adequate amounts of water, Metamucil forms a smooth, hydrophilic colloid. As this colloidal mass passes through the large intestine, it exerts a gentle, distending pressure within the lumen, thus initiating the peristaltic reflex necessary for evacuation.

A program of Metamucil therapy helps to restore proper tone to the intestinal musculature, thereby establishing proper bowel habits.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. Searle & Co.

Research in the Service of Medicine

COUNCIL ON CONSTITUTION AND BY-LAWS

L. A. Buie, Chairman—Rochester, Minn.
James Stevenson—Tulsa, Okla.
S. H. Osborn—Hartford, Conn.
F. S. Winslow—Rochester, N. Y.
B. E. Pickett, Sr.—Carrizo Springs, Texas
E. S. Hamilton—Kankakee, Ill.

AND ALSO

The President and the Speaker and the Vice Speaker of the House of Delegates of the Association.

COUNCIL ON PHARMACY AND CHEMISTRY

(Standing Committee of Board of Trustees)

Torald Sollmann, Chairman—Cleveland
E. M. K. Geiling—Chicago
W. C. Cutting—San Francisco
Joseph Stokes, Jr.—Philadelphia
C. Guy Lane—Boston
Carl A. Dragstedt—Chicago
Keith S. Grimson—Durham, N. C.
Henry K. Beecher—Boston
James P. Leake—Washington, D. C.
Morris Fishbein—Chicago
Perrin H. Long—Brooklyn
Elmer M. Nelson—Washington, D. C.
Isaac Starr—Philadelphia
Joseph Hayman—Cleveland
W. G. Workman—Bethesda, Md.
James Bordley, III—Cooperstown, N. Y.
Robert T. Stormont, Secretary—Chicago

COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION

(Standing Committee of Board of Trustees)

Frank H. Krusen, Chairman—Rochester, Minn.
Frank R. Ober—Boston
Howard A. Rusk—New York
Shields Warren—Boston
Anthony C. Cipollaro—New York
M. A. Bowie—Swarthmore, Pa.
G. M. Piersol—Philadelphia
W. W. Coblentz—Washington, D. C.
W. J. Zeiter—Cleveland
Derrick Vail—Chicago
A. L. Watkins—Boston
Felix Butte—Dallas, Texas
O. Glasser—Cleveland
D. M. Lierle—Iowa City
Ralph E. De Forest, Secretary—Chicago

COUNCIL ON FOODS AND NUTRITION

(Standing Committee of Board of Trustees)

Howard B. Lewis, Chairman—Ann Arbor, Mich.
J. S. McLester—Birmingham, Ala.
C. A. Elvehjem—Madison, Wis.
William J. Darby—Nashville, Tenn.
George R. Cowgill—New Haven, Conn.
C. S. Ladd—Washington, D. C.
John B. Youmans—Nashville, Tenn.
Charles S. Davidson—Boston
Clement A. Smith—Boston
L. A. Maynard—New York
James R. Wilson, Secretary—Chicago

COUNCIL ON INDUSTRIAL HEALTH

(Standing Committee of Board of Trustees)

A. J. Lanza, Chairman—New York
James S. Simmons—Boston
Rutherford T. Johnstone—Los Angeles
C. D. Selby—Port Huron, Mich.
Warren F. Draper—Washington, D. C.
O. A. Sander—Milwaukee
Henry H. Kessler—Newark, N. J.
Robert A. Kehoe—Cincinnati
Lloyd E. Hamlin—Chicago
W. P. Shepard—San Francisco
M. N. Newquist—New York
J. H. Sterner—Rochester, N. Y.
C. M. Peterson, Secretary—Chicago

COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

(Standing Committee of Board of Trustees)

James C. Sargent, Chairman—Milwaukee
Harold C. Lueth—Evanston, Ill.
Stafford Warren—Los Angeles
Herbert B. Wright—Cleveland
A. A. Brindley—Toledo, Ohio
Frank H. Lahey—Boston
R. L. Sensenich—South Bend, Ind.
Harold S. Diehl—Minneapolis
Perrin H. Long—Brooklyn
R. L. Meiling—Columbus, Ohio
Mr. C. Joseph Stetler, Secretary—Chicago

COUNCIL ON RURAL HEALTH

(Standing Committee of the Board of Trustees)

F. S. Crockett, Chairman—Lafayette, Ind.
D. G. Miller, Jr.—Morgantown, Ky.
C. S. Mundy—Toledo, Ohio
J. P. Jones—Camden, Ala.
F. A. Humphrey—Ft. Collins, Colo.
N. H. Gardner—E. Hampton, Conn.
A T. Stewart—Lubbock, Texas
J. F. Doughty—Tracy, Calif.
W. J. Weese—Ontario, Ore.
W. A. Wright—Williston, N D.
Mrs. A. Hibbard, Secretary—Chicago

COMMITTEE ON MENTAL HEALTH

(Standing Committee of the Board of Trustees)

L. H. Bartemeier, Chairman—Detroit
W. H. Baer—Peoria, Ill.
L. H. Smith—Philadelphia
M. Levine—Cincinnati
F. M. Forster—Washington, D. C.
H. T. Carmichael—Chicago
M. R. Kaufman—New York
R. J. Plunkett, Secretary—Chicago

COMMITTEE ON SCIENTIFIC EXHIBIT

L. W. Larson, Chairman—Bismarck, N. D.
James R. McVay—Kansas City, Mo.
Thomas P. Murdock—Meriden, Conn.
Thomas G. Hull, Director—Chicago

ADVISORY COMMITTEE

Howard F. Root—Boston
H. J. Corper—Denver, Colo.
James P. Leake—Washington, D. C.
Alton Ochsner—New Orleans
F. P. Moersch—Rochester, Minn.
F. S. Smyth—San Francisco

BUREAU OF LEGAL MEDICINE AND LEGISLATION
J. W. Holloway Jr., Director—Chicago

BUREAU OF HEALTH EDUCATION
W. W. Bauer, Director—Chicago

BUREAU OF EXHIBITS
Thomas G. Hull, Director—Chicago

BUREAU OF INVESTIGATION
Oliver Field, Director—Chicago

BUREAU OF MEDICAL ECONOMIC RESEARCH
Frank G. Dickinson, Director—Chicago

CHEMICAL LABORATORY
Walter Wolman, Director—Chicago

LIBRARY
Miss Magdalene Freyder, Librarian—Chicago

MARQUETTE SCHEDULES TWO POSTGRADUATE PROGRAMS

A course on "Diseases of the Chest" will be offered March 4, 11, 18 and 25 at Marquette University's School of Medicine, opening the spring postgraduate education program in the medical school.

Dr. Mischa J. Lustok, assistant clinical professor of medicine at Marquette, is chairman of the course which will be presented jointly with the Wisconsin Chapter, American College of Chest Physicians.

Guest speakers will include Dr. Benjamin M. Gasul, department of pediatrics and cardiology at Cook County Hospital, Chicago, Ill.; Dr. R. Drew Miller, consultant in chest diseases at the Mayo Clinic, Rochester, Minn.; and Dr. Erich M. Uhlmann, director of the tumor clinic, Michael Reese Hospital, Chicago.

Other speakers will represent Marquette's medical school, the medical school of the University of Wisconsin, the American College of Chest Physicians, the American Academy of General Practice, and the Veteran's Administration Hospital, Wood, Wis.

The course schedule is as follows:

March 4 **Diagnostic Significance of Presenting Symptoms**
March 11 **Interpretation of X-Ray of the Chest**
March 18 **Cardiovascular Diseases**
March 25 **Pulmonary Diseases**

Members of the American Academy of General Practice will be allowed 16 credit hours for the postgraduate course. Registration should be made through the Director of Postgraduate Programs, Marquette University Medical School, Milwaukee, Wis.

A postgraduate course on "Arthritis and Allied Rheumatic Disorders" will be presented April 15, 22 and 29 by Marquette University School of Medicine. Dr. Mark Garry, assistant clinical professor of medicine at Marquette, will direct the course.

Lectures and case presentations will be held at the medical school and at the Veteran's Administration Hospital. Leading contributors in the fields of inflammatory and degenerative joint disorders will appear under the auspices of the Wisconsin Arthritis and Rheumatism Foundation.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favil, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.

"particularly useful... for the routine therapy of the menopause"[1]

ESTINYL

ESTINYL® Tablets alleviate menopausal symptoms rapidly and smoothly in very small doses. A derivative of estradiol, ESTINYL (ethinyl estradiol) produces the sense of well-being characteristic of therapy with natural estrogens.

Tablets of 0.02, 0.05, and 0.5 mg.

1. Perloff, W. M.: Am. J. Obst. & Gynec. 58:684, 1949.

Schering CORPORATION
BLOOMFIELD, N. J.

ESTINYL

SCHERING

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Daly 8-1021

YOU TOO, CAN ENJOY WISCONSIN LIFE

They are just an average American family who live in a nice home that they are paying for. They drive a good car, entertain friends, and enjoy their regular vacation.

But doesn't that demand a large income? Not necessarily. You see, Jim and Mary, have done some sound planning. He owns enough Wisconsin Life, which added to his Social Security benefits will provide the needed monthly income, should Jim be taken out of the picture. The premium for that amount of life insurance is the first item in their budget. You see, that releases the rest of Jim's income for better living now. It also gives him a lot of peace of mind. Forced saving isn't necessary.

You too can enjoy this security and peace of mind. Suppose you are 30 years old, married, have two small children and qualify for maximum Social Security benefits. Do you know that for only $15.46 a month you can assure your family a monthly income of $268.75? Our representative will gladly give you details of the plan without obligation.

Wisconsin Life Insurance Co.
30 W. Mifflin St. Madison, Wis.

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

17–Ketosteroid
Determinations
Quantitative Gonadotrophin
Assays
Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES
5001 West Belt Line Highway
MADISON 5, WISCONSIN

CORRESPONDENCE

The University of Wisconsin
STATE OF WISCONSIN GENERAL HOSPITAL
Madison

Dear Sir:

Enclosed is a letter from the Federal Security Agency relative to the Hoxsey Cancer Clinic. I believe a note should be inserted in the Wisconsin Medical Journal relative to the court's decision.

Sincerely yours,
A. R. CURRERI, M.D.

FEDERAL SECURITY AGENCY
Food and Drug Administration
Washington 25, D. C.

September 9, 1952

Dear Dr. Curreri:

You may be interested in the enclosed opinion of the U. S. Court of Appeals for the Fifth Circuit in the case of U. S. v. Hoxsey Cancer Clinic, a Partnership, and Harry M. Hoxsey, an Individual. This opinion is the result of an appeal in a vigorously contested case tried in the U. S. District Court at Dallas, Texas. It reverses the judgment of the trial Judge (William H. Atwell, N. Dist. of Texas) and directs that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink, liquids intended for the treatment of cancer in man.

In many parts of the country, people are taking the Hoxsey medicines in the belief that they may be an effective treatment for cancer. Friends and relatives of cancer victims frequently query local physicians concerning this treatment. You may wish to publish information about this case so that physicians will have the facts at hand concerning these drugs, in the event of such inquiries.

The following important principles are laid down in the Circuit Court opinion, based on testimony by cancer experts.

1. "***there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."

2. "***the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."

3. "***despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radio-active by-products of atomic bomb production."

4. "***Upon such subjects a court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony***."

The Hoxsey Clinic is located in Dallas, Texas, and ships its drugs to patients in many other States. According to the unanimous opinion of the Court of Appeals, consisting of Judges Russell, Hutcheson, and Rives, "the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines are efficacious in the cure of cancer is***false and misleading. The evidence as a whole does not support the finding of the trial Court that 'some it cures, and some it does not cure, and some it relieves somewhat.

Under the law the defendants still have the right to petition for review by the U. S. Supreme Court.

Background information on the Hoxsey Clinic is given in the attached report prepared by the Division of Medicine of the Food and Drug Administration.

Very truly yours,
C. W. CRAWFORD
Commissioner of Food and Drugs

Attachment—Decision U. S. Court of Appeals for the Fifth Circuit (Hoxsey—7-31-52). Report on Background of Harry M. Hoxsey and Hoxsey Cancer Clinic.

The State of Wisconsin
WISCONSIN STATE COLLEGE
Oshkosh, Wisconsin

Dear Sir:

We wish to thank your society for making available the services of Dr. Edgar S. Gordon, as a speaker for our Health Workshop group this summer. We also invited our biology class to hear this lecture, and so had a good sized group to hear Dr. Gordon.

I heard this very fine lecture, and considered it one of the finest I have ever heard. It brought us up-to-date on some of the very newest developments in the field of medical research.

Sincerely yours,
J. H. SMITH
Director of Summer School

(Continued on page 36)

Home Location of Respirators (Iron Lungs) Throughout Wisconsin

Appleton, St. Elizabeth's (2)
Burlington, Burlington Memorial (1)
Eau Claire, Luther (1) (*4)
Eau Claire, Sacred Heart (2)
Fond du Lac, St. Agnes (2) (*1)
Green Bay, St. Vincents (1)
Janesville, Mercy (1)
Kenosha, Kenosha (2) (*1)
La Crosse, La Crosse Lutheran (2)
La Crosse, St. Francis (2) (*5) (†1)
Madison, St. Mary's (†1)
Madison, State of Wisconsin General (6) (*3) (†8)
Manitowoc, Holy Family (2)
Marinette, Marinette General (2)
Merrill, Holy Cross (1)
Milwaukee, Milwaukee Children's (2)
Milwaukee, Milwaukee County (*1)
Milwaukee, South View (5) (*1)
Monroe, St. Clare (*1)
Neenah, Theda Clark Memorial (1)
Oconto, Oconto City & County Hosp. (1)
Oshkosh, Mercy (1)
Plymouth, Plymouth (2)
Racine, St. Luke's (1)
Racine, St. Mary's (1)
Waukesha, Waukesha Memorial (1)
Waupun, Waupun Memorial (2)
Wausau, St. Mary's (1) (*6) (†3)
West Bend, St. Joseph's (1) (*1)
Wild Rose, Wild Rose Hospital (1)

* Temporary iron lungs provided by National Foundation for Infantile Paralysis, but which will be returned to equipment pools when no longer needed.

† Temporary rocking beds provided by National Foundation for Infantile Paralysis, but which will be returned to equipment pools when no longer needed.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

Dr. John M. Dodd†	1930
Dr. Cornelius A. Harper†	1930
Dr. John J. McGovern†	1931
Dr. Louis M. Jermain†	1931
Dr. Edward Evans†	1931
Dr. Mina B. Glasier†	1932
Dr. Arthur W. Rogers†	1934
Dr. Rock Sleyster†	1934
Dr. Olin West	1934
Edward A. Birge, Ph. D.**†	1935
Dr. Arthur J. Patek†	1935
Dr. Joseph F. Smith†	1937
Dr. Eben J. Carey†	1938
Dr. William S. Middleton	1938
Dr. Fred G. Johnson†	1939
Dr. William D. Stovall	1940
Dr. Ludvig Hektoen***†	1941
Dr. Stephen E. Gavin	1944
Dr. F. Gregory Connell	1947
Dr. E. R. Schmidt	1949
Dr. Armand J. Quick	1950
Dr. F. A. Stratton	1951

** Then president of the University of Wisconsin and professor of zoology.

*** Centennial Award.

† Deceased.

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Basic Medical Physiology. By W. B. Youmans, Ph.D., M.D., professor of Physiology, University of Wisconsin, Madison. Chicago, The Year Book Publishers, Inc., 1952. Price $7.50.

This book presents in 409 pages the basic principles of physiology. Emphasis is placed on the listing of well established facts. Lengthy discussions of controversial points and experimental evidence are at a minimum. However this book is no mere catalogue of isolated facts. The subject matter is presented in such a fashion that a clear picture of the essential workings of a particular organ or system is readily formulated. This end is achieved by clever organization of material, numerous illustrations, clear direct style of writing, concise definition of terms and brief discussions of the significance of interrelation of the facts presented. Of particular interest to the physician will be the author's discussion of significant physiologic disturbances in a number of pathologic conditions.

The book will be an important addition to the library of any physician interested in reviewing basic physiology and in discovering how the present day knowledge of this basic science can be integrated with clinical medicine.—Q.R.M.

Your Diabetes; a Complete Manual for Patients. By Herbert Pollack, M.D., associate physician for metabolic diseases, Mount Sinai Hospital, New York. Marie V. Krause. M.S., consulting dietician. Second edition. New York, Paul B. Hoeber, Inc., 1951. Price $3.00.

The physician treating diabetes needs an ally—a well informed patient who can cooperate intelligently and actively in the management of his disease. Some large clinics hold formal classes for their diabetic patients but the individual practitioner, or small group, finds this approach scarcely practicable. Doctor Pollack has produced a book which should be of great assistance in meeting this need. If an apology is needed for adding one more to the long list of "diabetic manuals" for the layman, it is quickly found in the excellence of this essay.

The initial chapter, "You Can Live a Normal Life," is essentially an inspirational "pep talk," which should go far to dispel the fear, rebellion, and defeatism with which many patients react when informed that they have this disease. The book proceeds from this much needed introduction to a detailed presentation of the clinically applicable features of our knowledge of insulin action and the metabolism of foodstuffs and from these logically develops in considerable detail the technics employed in administering insulin, prescribing diets, and handling the various complications and emergencies which may arise in the course of a diabetic's day-to-day existence. The patient is even shown that with only a modicum of mental arithmetic he may select a restaurant menu containing such items as Spanish melon, cold Madrilene, and Filet of flounder Bonne Femme, or may indulge in such orthodox Passover dishes as Chremslach-Fleishig or Kneidlach. The author writes in simple, direct terms which can be understood easily even by juvenile patients and yet, in so doing, sacrifices to simplicity no bit of physiologic information which should be of help to the patient. The text is medically sound and while some physicians may find that its regimens differ slightly from their own, there is little with which even enthusiasts for some of the less common methods of management could really quarrel.

An effort is made to present and reconcile, or at least clarify, these conflicting programs of treatment, thus materially assisting the patient who is often left floundering by the dogmatically expressed views of different doctors. There are a few instances, for example, where the described technics differ from the methods of the present reviewer and yet the presentation is such that there would be little difficulty in explaining to patients the reasons for the difference in views and in reaching a rational resolution of the difference.

This book should be outstanding among the various diabetic manuals for laymen and can be highly

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses — Winter 1952-53

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 19, February 2, February 16
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2
Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16
Basic Principles in General Surgery, Two Weeks, starting March 30
Gallbadder Surgery, Ten Hours, starting April 20
Surgery of Colon & Rectum, One Week, starting March 2
General Surgery, One Week, starting February 9
General Surgery, Two Weeks, starting April 20
Fractures & Traumatic Surgery, Two Weeks, starting March 2
GYNECOLOGY—Intensive Course, Two Weeks, starting February 16
Vaginal Approach to Pelvic Surgery, One Week, starting March 2
OBSTETRICS—Intensive Course, Two Weeks, starting March 2
PEDIATRICS—Intensive Course, Two Weeks, starting April 6
MEDICINE—Intensive General Course, Two Weeks, starting May 4
Electrocardiography & Heart Disease, Two Weeks, starting March 16
Allergy, One Month and Six Months, by appointment
UROLOGY—Intensive Course, Two Weeks, starting April 13
Ten-Day Practical Course in Cystoscopy starting every two weeks
DERMATOLOGY—Intensive Course, Two Weeks, starting May 11

Teaching Faculty—Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

LIQUID PLASMA

U. S. LICENSE 187

Half pint units of liquid plasma available.
(Recipient set not included.)

Save by ordering directly from:

JUNIOR LEAGUE BLOOD CENTER

763 No. 18th St. Milwaukee 3, Wis.

recommended to physicians as a very valuable aid in the instruction and management of their diabetic patients.

Vocational Services for Psychiatric Clinic Patients. By Thomas A. C. Rennie, M.D., Cornell University Medical College and the New York Hospital; and Mary F. Bozeman, of the rehabilitation project, National Association For Mental Health. Published for the Commonwealth Fund, Cambridge, Mass., Harvard University Press, 1952. Price $1.25.

This Commonwealth Fund book is one of a series dealing with problems and resources in the rehabilitation of the mentally ill. It is the report of a study sponsored by the National Association for Mental Health and directed by Dr. Thomas Rennie, noted psychiatrist of Cornell University Medical College and Mary F. Bozeman of the staff of the sponsoring organization.

Attention was directed toward the vocational needs of two groups of patients under psychiatric outpatient care, one within the metropolitan area of New York City and the other in a smaller, midwestern community, Jackson, Michigan.

Inquiry has been focused in four areas; the prevalence of vocational problems in these groups of patients, methods of determining which problems can best be resolved by psychiatry alone and which by the dual approach of psychotherapy and vocational help; the most effective ways of securing assistance with vocational problems and finally an evaluation of the results of coordinated psychotherapy and vocational service.

Findings indicated that 80 per cent of the patients studied brought vocational problems to the attention of the psychiatrist. Of these, 25 per cent received vocational service in addition to psychotherapy and two-thirds of the latter group were considered benefited vocationally. Patients under 30 years of age, particularly high school and college students, seemed most in need of vocational service. Other groups with a high incidence of vocational problems were those with severe physical handicaps, recent immigrants, and patients over 50 years of age.

Best results occurred when clinic and vocational service personnel operated as a team in determining the patients' total needs and making plans to meet these. It was recognized that the psychiatrist must have final authority and responsibility for deciding which patients have the capacity to benefit from vocational services.

This book would appear to be a valuable addition to the literature on rehabilitation of the mentally ill. It has use for medical personnel treating patients with varying degrees of mental and emotional disturbance and also for the social workers, vocational councilors and others working for the welfare of similar groups of patients.

New and Nonofficial Remedies. Issued under the direction and supervision of The Council on Pharmacy and Chemistry of the American Medical Association. Philadelphia, London, and Montreal, J. B. Lippincott Company, 1952.

Prescription Perfect

RED LABEL • BLACK LABEL

Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.

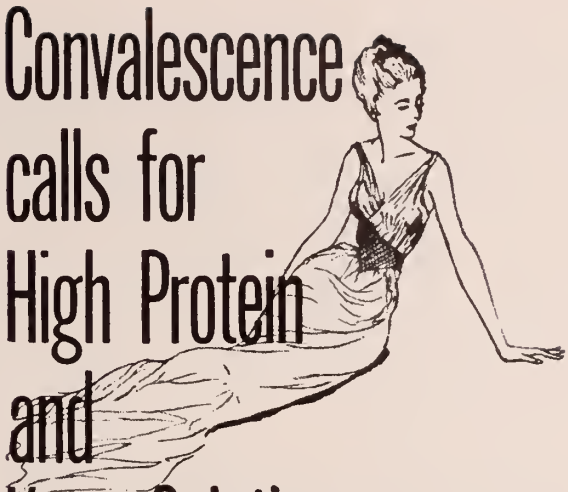
Born 1820 . . . still going strong

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

Convalescence calls for High Protein and Knox Gelatine



Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Loss of nitrogen cannot be prevented; however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect.[3]

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[1] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

Knox Gelatine is easy to digest, while its supplementary dietary nitrogen will furnish protein without other substances, especially salts of potassium which are retained during convalescence; without excess fat and carbohydrate, which are not needed especially; and without a food volume which may interfere with intake.

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.

AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES

Write today for your free copy "Feeding the Sick and Convalescent." Knox Gelatine, Johnstown, N. Y., Dept. WS

KNOX GELATINE U.S.P. ALL PROTEIN NO SUGAR

The 1952 edition of this manual continues the same general content and format of last year's edition and it contains approximately 50 additional pages. One of the new drugs listed for the first time is cyclocumarol (Cumopyran-Abbott), a blood anticoagulant which was introduced and studied here at Wisconsin. Other drugs listed for the first time include NPH insulin, phenacemide (Phenurone-Abbott), and thiamylal (Surital-Parke, Davis). As before, this volume contains much valuable information concerning all but the older therapeutic agents. In addition, the bibliography of unaccepted products gives quick reference to information on many of the questionable remedies which have been introduced commercially from time to time.—J.E.S.

The Old Egyptian Medical Papyri. By Chauncey D. Leake, vice-president, University of Texas—Medical Branch, Galveston. Lawrence, Kansas, University of Kansas Press, 1952. Price $2.00.

This short essay formed the Clendening Lectures of 1951. Doctor Leake discusses, especially, therapeutics in these oldest known medical books, and gives a few unpublished data on the Hearst papyrus. He calls incantations "recitals," and mostly ignores the magical elements in Egyptian medicine.—E.H.A.

Elementary Medical Statistics, The Principles of Quantitative Medicine. By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., professor of medical statistics, division of medical statistics, the department of preventive medicine, New York University College of Medicine. Philadelphia and London, W. B. Saunders Company, 1952.

The principal value of this book results from the large number of medical examples that are used for analysis. In all but a few instances the mathematics employed are elementary consisting only of arithmetic and the simplest of algebraic processes. No attempt is made to submit mathematical proof of the statistical methods employed. This would seem entirely justifiable in a book intended for the non-mathematical group for which it is written, but leads to difficulty and involvement in attempting to explain certain matters in ordinary language. Discussion of the more important factors involved in the design of experimental and clinical investigation and the avoidance of errors in interpreting the material form a large and important part of the context.

The two principal adverse criticisms that might be made of this book are lack of clearness of statement in certain instances which involves frequent re-reading and difficulty in understanding the meaning of the subject matter, and the employment of methods before they are adequately defined. Examples of the latter include the use of the standard deviation of the mean and the determination of "degrees of freedom" in a sample of data.—J.A.E.E.

Histopathological Technic. By Aram A. Krajian, Sc.D., formerly in department of pathology, Los Angeles County General Hospital, Los Angeles, Calif.; and R. B. H. Gradwohl, M.D., pathologist to Christian Hospital, director, Gradwohl School of Laboratory and X-Ray Technique, St. Louis, Mo. Second edition. St. Louis, The C. V. Mosby Company, 1952. Price $6.75.

This little book is a meaty account for the technician in histopathology for both animals and plants. Many basic and general technics are listed and the pitfalls and causes for failures are discussed. Certain routine technics are amply covered and some are given in great detail. Staining technics for the histopathology of the nervous system are given at length. It is a little regrettable that certain essential technics such as procedures with bone, especially decalcification and serial sectioning in celloidin, are very superficially treated. Blood technics are completely omitted. In spite of these omissions it is a very serviceable book for depicting the general and some special technics. The listing of many simple aids and "tricks of the trade" are of value.—T.H.B.

Research in Endocrinology. By August A. Werner, M.D., and associates. 1952.

Under the somewhat misleading title of Research in Endocrinology, in which this reviewer expected to find recent advances in the field of endocrinology, the city editor of the Belleville, Illinois Daily Advocate has put together a monograph about August A. Werner. It contains biographical material, reviews some of his research interests, and con-

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 Milwaukee, Wis.

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clyboum St. Milwaukee 3, Wisconsin

COMPLETE OPHTHALMIC SERVICE FOR THE PROFESSION
Since 1913

BRANCH LABORATORIES SERVING WISCONSIN:

Eau Claire, Wausau, La Crosse, Beloit, Superior, Stevens Point, and Duluth, Minn.

Benson
OPTICAL COMPANY

MAIN OFFICE AND LABORATORY • MINNEAPOLIS, MINN.

Branch Laboratories in Principal Cities of Upper Midwest

today's health a must!
for your reception room

Physicians' Half-Price Rates

4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

Your Visit to Milwaukee

Is Made More Enjoyable by Stopping at the SCHROEDER

Metropolitan atmosphere
Cocktail Lounge
Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

The Treatment of
ALCOHOLISM..
A MEDICAL
PROBLEM

In addition to private conferences as needed, group re-education is indispensable in leading the patient back toward total abstinence.

The concept of alcoholism as a medical problem, now generally accepted, is basic in the successful control of the "problem drinker."

At The Keeley Institute the therapeutic regimen is formulated on this premise. Specialized care of the individual patient rests in the hands of a highly experienced staff of physicians who supervise every step of the patient's progress.

Aversion treatment is not used, nor is restraint employed. Rather, the patient is aided toward rehabilitation through highly coordinated diet therapy, re-education, exercise and pleasant activities in an environment conducive to wholesome normal living—all under careful medical supervision.

The referring physician is kept informed of the patient's progress and receives a summary of the case upon the patient's dismissal.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

cludes with reprints of 16 published papers. It is the reviewer's opinion that the book will serve no useful purpose and is conceived and presented in poor taste.—E.C.A.

The Scalp in Health and Disease. By Howard T. Behrman, A.B., M.D., assistant clinical professor of dermatology, New York University Post-Graduate Medical School; adjunct dermatologist, Mount Sinai Hospital; attending dermatologist, Hillside Psychiatric Institute; formerly associate dermatologist, Bellevue Hospital, and assistant attending dermatologist, University Hospital. St. Louis, The C. V. Mosby Company, 1952. Price $12.50.

This book gives excellent dissertations on the anatomy, chemistry, and physiology of the hair, its endocrinology, anthropology, and embryology, the diagnosis and treatment of its diseases, and the use and abuse of measures to alter its appearance. Most of the photographs are good, particularly those dealing with the laboratory diagnosis of fungus infections of the scalp. The formulary is excellent in that for each disorder several prescriptions are given and the ingredients contained therein are now available in any pharmacy. Each chapter has a complete bibliography.

This book should be valuable to students, physicians, and those interested in any problem of the hair and scalp.—S.A.M.J.

CORRESPONDENCE

(Continued from page 29)

State University of Iowa
University Hospitals
Department of Obstetrics and Gynecology
Iowa City, Iowa

Dear Sir:

I want to take this opportunity to thank you for the chance of again appearing as a speaker on the Spring Clinics. I always thoroughly enjoy such circuits because they are always well attended and are so well organized that it is no effort on the part of the speaker except presenting his own material. I was impressed by the interest of those who attended and I think that real progress has been made in the last ten years with the doctors of Wisconsin. They seemingly are very much interested in postgraduate education and in the problems of the society, the medical school and health department—more than they were about ten years ago.

Sincerely,
W. C. Keettel, M. D.

Central Agency for Chronically Ill
756 N. Milwaukee Street
Milwaukee 2, Wisconsin

Dear Sir:

Thank you for sending me the copy of the Medical Forum. I will be glad to get subsequent copies.

The article written by Mr. Otis reflects the thinking of the committee.

I think your Forum could be of great assistance to us who are concerned over the care of the chronically ill. I have a feeling that many doctors are not sufficiently informed on the problems associated with maintaining nursing home standards. If they, as private physicians, could counsel with their patients and urge the families to investigate before placing the patients, many sad experiences could be avoided. I realize that doctors are busy people and that they probably assume that all nursing homes are satisfactory. I wish this were true, but, unfortunately, it is not, so if we could alert them it might prevent some unfortunate situations.

Sincerely,
THEDA L. WATERMAN
Executive Director

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

COSMETIC *HAY FEVER?*
Prescribe UNSCENTED AR-EX Cosmetics
When perfumes or scented cosmetics cause allergic reactions — prescribe UNSCENTED AR-EX COSMETICS Clinically tested to meet your high standards. Smart, fashion-right for patient acceptance. All needed beauty aids. Send for free Formulary
UNSCENTED
AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

AR-EX
HYPO-ALLERGENIC
Cosmetics
Clinically tested on allergic patients for use by allergic patients

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2611 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.
FOUR STORES
Complete Stocks Of Medical Specialties
Orders Filled Promptly

PHYSICIAN AND HOSPITAL SUPPLIES

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Post-Graduate Medical Institution in America)

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

EYE, EAR NOSE AND THROAT

A three months' combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuroanatomy; anesthesia; physical medicine; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics; attendance at departmental and general conferences.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue — MILWAUKEE, WISCONSIN — Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

ACCIDENT • HOSPITAL • SICKNESS
INSURANCE
For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$18,900,000.00 PAID FOR CLAIMS

50 years under the same management

400 First National Bank Building — Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

WANTED: Midwest group of 20 physicians have opening for an assistant in general surgery including traumatic, industrial, and minor injuries; liberal salary depending upon experience or previous training. Address replies to box 454 in care of the Journal.

PHYSICIAN WANTED, preferably out of internship, as associate in general practice which includes a liberal amount of surgery. Chance for partnership affiliation. Address replies to box 456 in care of the Journal.

AVAILABLE FOR YOUNG PHYSICIAN: Office space and equipment for general practitioner. Excellent location in business-residential section of Madison. Will arrange lease and ultimate purchase of equipment, if so desired. Write box 460 in care of the Journal to arrange for interview and inspection of office.

FOR SALE: All steel mahogany color examining table, instrument cabinet, stool, and waste receptacle. All pieces new except for slight damage to upholstery of examining table which can be repaired. Also brand new Castle sterilizer. Will sell all cheap to move fast. Address replies to box 461 in care of the Journal.

FOR SALE: Complete office equipment and library of deceased physician. For further information write to box 472 in care of the Journal.

PSYCHIATRISTS AND PHYSICIANS NEEDED: The State of Wisconsin is expanding and developing treatment services under the direction of Dr. Leslie Osborn, Division of Mental Hygiene, and of Mr. Russell Oswald, Division of Corrections . . . Professional staffs being increased. New patient units under construction . . . Positions at Chippewa Falls, Madison, Oshkosh, Union Grove and Waupun.

Wisconsin has had 47 years of uninterrupted career service . . . Eligibility for medical positions based on evaluation of credentials by committee of professional consultants. Starting salaries—Physician I $7200, Psychiatrist I $7620. More experienced psychiatrists start at higher levels.

Division of Mental Hygiene program directly linked with Medical School at University of Wisconsin . . . Approved residency stipends available July, 1953. First year $2500; second $3000; third $3600; then 2 years as Psychiatrist I. Write Robert C. Parkin, M.D., Medical Recruiting Consultant, Bureau of Personnel, State Capitol, Madison, Wisconsin.

FOR RENT: Desirable office space, consisting of 2 large treatment rooms, spacious furnished waiting room. Will share lab. Air conditioned building in new heavily populated area. Partly occupied by general physician and dentist. Write Maurice Olsen, M.D., 7623 W. Burleigh, Milwaukee 10, Wis.

WANTED: Bright experienced girl for all around work in general physician's office. Experienced in bookkeeping, typing, and receptionist work. Another girl employed. Must be willing to work 2 or 3 evenings a week. Write Maurice Olsen, M.D., 7623 W. Burleigh, Milwaukee 10, Wis.

FOR RENT: Two large rooms in Madison, which are arranged for a physician's office. Excellent location, reasonable rent. Call 5-7782 or 5-0937 for further information.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE by retired physician. Fischer diathermy machine, Miller short wave machine, and McIntosh polysine generator. Best offer accepted. Write or call Dr. E. M. Rice, 1738 Alta Vista Ave., Wauwatosa 13, Wis. Phone Bl. 8-2300.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

FOR SALE: General and surgical practice in a village of 600 with excellent surrounding community, a small modern 16 bed hospital, and excellent home, situated on an acre of land. This business nets better than $15,000 per year. Address replies to box 138, Birnamwood, Wis.

EXPERIENCED PHYSICIAN WANTED, by a clinic in west-central Wisconsin, to replace a general practitioner who is going into service. Excellent salary. Address replies to box 463 in care of the Journal.

PHYSICIAN WANTED as an associate for a well established practice including surgery in a college and industrial city of about 6,000 in the Fox River Valley. Fully equipped and newly remodeled ground floor office of 12 rooms. Staff appointment open in 50 bed hospital. Salary, percentage, or private enterprise basis. Present M.D. owner unable to carry on practice alone due to health. Address replies to box 464 in care of the Journal.

RADIUM FOR SALE: One 50 mg. and thirteen 10 mg. cells with variety of capsules and application instruments, at 10 per cent below market price of radium. Also divided. Address replies to box 465 in care of the Journal.

FOR SALE: Active general practice and equipment in modern office building in Manitowoc. Owner is Priority II and has been drafted. Outright sale, rent, or partnership considered. Address replies to box 466 in care of the Journal.

GENERAL SURGEON, four years training, large general hospital, age 33, desires association with general surgeon, group, or clinic. Call Milwaukee Spring 4-9314 or write box 467 in care of the Journal.

WANTED, oto-laryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

FOR SALE: Resectoscope, never used. A.C.M.I. 28 French, complete with box, cords, lights, 2 sheaths, resecting unit, and extra cutting tips, etc. Address replies to box 469 in care of the Journal.

PHYSICIANS, with or without public health training, and pediatricians needed in maternal and child health program at salaries from $6,908 to $9,887. Five day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, City Hall, Milwaukee, Wis.

PHYSICIANS WANTED: Obstetrician and gynecologist, preferably a young man, Board certified, the young man or woman to be associated in the department of pediatrics. Also a young man with one year surgical residency to be personal assistant to A. S. Jackson, M. D. Address replies to A. S. Jackson, M. D., 16 South Henry Street, Madison, Wisconsin.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2-8118.

INTERNIST, 46, board qualified, senior partner of group at present, military class 4, desires association with internist or group. Must be town of 10,000 or over and have a pathologist; expected remuneration $1,000 a month with eventual partnership. Address replies to box 470 in care of the Journal.

WANTED: Obstetrician, certified or Board qualified, for young progressive Wisconsin group. Excellent chances for development. Address replies to box 453 in care of the Journal.

FOR SALE: One 30 MA-90 KV Westinghouse X-Ray mobile unit, bucky table and other complete accessories. Office equipment including scale, exam table, surgical instruments and cabinet, short wave diathermy machine and B. D. Manometer. Write to Mrs. Viola Berg, Gillett, Wisconsin.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkln, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- F. J. Mellencamp, Milwaukee
Secretary ---------- E. H. Pawsat, Fond du Lac
Vice-chairman ------- N. L. Low, Racine
Delegate ---------- K. B. McDonough, Madison
Alternate ---------- K. J. Winters, Wauwatosa

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	12
Ames Company, Inc.	6
Ar-Ex Cosmetics	37
Audiophone Utilities	30
Ayerst, McKenna & Harrison, Ltd.	21
Barr X-Ray Company	34
The Bayer Company	10
Benson Optical Company	35
Bergmann Prescription Center	18
Camel Cigarettes	9
Canada Dry	33
Central Drug	18
Chicago Medical Society	16
Ciba Pharmaceutical Products	19
Cook County Graduate School of Medicine	32
Doerflingers	37
Endocrine Laboratories	28
Hotel Schroeder	35
House of Bidwell	30
Hurley X-Ray Company	28
Junior League Blood Center	32
Keeley Institute	36
Kennedy-Mansfield	18
Knox Gelatin	33
Lederle Laboratories	facing page 18
Lilly, Eli and Company	22
Mallard, Incorporated	14
Mallatt Pharmacy	18
Marsh and McLennan	20
Mather Pharmacy	18
Mayer Drug	18
Mead Johnson and Company	43
Medical Protective Company	28
Merck and Co.	7
Milwaukee Sanitarium	44
New Orleans Graduate Medical Assembly	4
New York Polyclinic	37
Orthopedic Appliance Company	34
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	15
Philip Morris	13
Physician Casualty Association	38
Physicians and Hospitals Supply Co.	17
Professional Business Service	59
Radium Emanation Corporation	5
Rennebohm's	18
Rogers Memorial Sanitarium	44
Sacred Heart Sanitarium	16
St. Croixdale Sanitarium	5
Schering	27
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	38
Stanley, Inc.	37
Summit Hospital	20
Time Insurance Company	57
Upjohn Company	11
Winthrop-Stearns, Inc.	8
Wisconsin Life Insurance Company	28

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron–Washburn–Sawyer–Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia–Marquette–Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bagley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake–Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	H. W. Harns Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospita
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. M. Albino 710 Main Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. E. Martineau Elkhart Lake	J. F. Hildebrand 1011 N. 8th Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	C. F. Meyer Mondovi	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	C. A. Ender Viroqua	Last Wednesday
Walworth	R. S. Galgano Delevan	K. C. Bill Elkhorn	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 707 Oakland Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	E. E. Debus Wisconsin Rapids	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.
** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 FEBRUARY, 1953 Number 2

Desmoid Tumors*

By JOHN R. STEEPER, M. D.**
Madison

DESMOID tumor is a benign fibrous tissue growth occurring most typically in the anterior abdominal wall. Although closely related histologically to ordinary fibromas, these tumors have distinctive characteristics, which have led to their classification as a separate clinical entity.

The first recorded description of this tumor was by Macfarlane in 1832, and the term "desmoid," freely translated as "tendon-like," was suggested in 1838 by Mueller. Since that time sporadic case reports have appeared in the world literature.

Occurrence

Desmoid tumors, or desmomas, are of infrequent occurrence as can be judged by the fact that in 30 years only 77 patients with this condition were seen at the Mayo Clinic. In 1943 Pack reported 17 cases from the files of the New York Memorial Hospital, going back over a period of 26 years.

One of the most characteristic features of this condition is its predilection for women of childbearing age. In collected case reports, approximately 80 to 90 per cent of these tumors occurred in women, and of these women some 70 to 90 per cent had borne children. The most obvious inference is that fibromas of the abdominal wall arise in muscles traumatized by labor or gestation, although there is some evidence to suggest that the sex hormones may play a contributing role.

Age Incidence

In women, most of the tumors occur during the childbearing years from 20 to 40. In males, such growths, when they occur, are found much later in life. Isolated reports of this tumor in childhood may be found, and one congenital case has been described by Brockman.

Location

The great majority of desmomas occur within the flat muscles of the anterior abdominal wall. Of the 77 cases reported by Pearlman and Mayo, 55 were in the abdominal wall; 12 were found elsewhere. Those located in other areas in the body occurred in the muscles of the shoulder, neck, arm, jaw, leg, and foot.

The lower abdomen is a much more frequent site of the tumor than the upper, and the right side is more often affected than the left. The growth commonly arises near the attachment of the abdominal muscles to the bony pelvis so that they are mistakenly thought to be of osseous or periosteal origin.

Etiology

As mentioned previously, muscle trauma is considered to be the chief factor in the development of desmoid tumors. Muscle tears during gestation and labor suggest a plausible explanation for the frequent appearance of these tumors during or shortly after pregnancy. The occurrence of desmomas in old surgical scars is further evidence of the role of trauma in their development. Green described a case in which a tumor developed in the inguinal canal after the patient had worn a truss for a period of 10 years.

Geschickter and Lewis suggested a possible causal relationship between the sex hormones and desmoids. These authors pointed out the similarity of these tumors to fibromyomas of the uterus and fibroadenomas of the breast, the latter two having a well-known relationship to female endocrine physiology. Their experimental work showed that all three of these tumors have a special ability to concentrate pituitary gonadotropic substance and estrogenic substance. Bio-assay of one desmoid tumor yielded 13,000 rat units of gonadotropin per kilogram.

Several clinical characteristics of desmomas give further evidence of endocrine factors in their development. According to Pack, these tumors respond slowly, but satisfactorily, to high-voltage x-rays, in spite of the fact that their histologic structure suggests radioresistance. This is true only of lower abdominal desmomas, in which treatment of the tumor results in castration by radiation. It is assumed that loss of ovarian function in some way causes regression of the desmoma. Following this hypothesis further, Pack caused regression in

* Presented before the Wisconsin Surgical Society, April 26, 1952.

** From the department of surgery, Jackson Clinic, Madison, Wis.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

a malignant desmoid tumor of the shoulder by irradiation of the ovaries alone.

Desmomas in males are radioresistant, perhaps because of a lack of the ovarian factor. Administration of sex hormones has been suggested, but reports of such treatment have not appeared in the literature.

Pathology

In gross appearance desmomas resemble other fibroid tumors except in their lack of a definite capsule. The tumor is of firm, rubbery consistence and greyish-pink color; interlacing fibrous bundles are plainly visible on the cut surface. In large specimens the center may show softening and cystic degeneration. Poor demarcation of the tumor margin from the surrounding muscle gives the appearance of invasive growth.

The histologic structure is that of a cellular fibroma with interlacing whorls and bundles of fibrocytes. Many authors have pointed out the similarity of these tumors to uterine fibroids. Cross-section appearance of the tumor recapitulates its growth history; the center of the tumor is obviously older, it is less cellular, there are many collagen fibers, and the fibrocytes are smaller and more mature. At the periphery the tumor is more cellular, and there is less collagen. The fibroblasts in this area appear more active and can be seen invading the surrounding striate muscle. Many of the adjacent muscle fibers appear to be undergoing degeneration, and frequent giant cells may be seen. There is conspicuous lack of encapsulation.

This tumor is not malignant in the sense that it may produce distant metastases; no such cases have been reported. However, it is locally invasive, and recurrences are apt to occur after inadequate excision. In one case reported by Pack the tumor recurred six times after surgical removal. Invasion of bone and peritoneum may occur, although skin is involved only by ulceration due to pressure necrosis. Because of their slow growth, most of these tumors are seen and treated before they attain large size; however, if neglected, they may become massive. The largest recorded desmoma was observed by Rokitanski in 1850; this specimen weighed 17 kg.

Clinical Manifestations

The average desmoid tumor produces few, if any, symptoms. In a typical case the patient notices, quite by accident, a small, firm, nontender mass in the lower abdomen. Although the larger tumors may cause dull pain or dragging sensations, most of these lesions are painless. The patient seeks medical advice because of a fear of cancer, not because of troublesome symptoms.

On examination, the tumor is felt to be smooth in outline and hard in consistency; it will be found to lie beneath the skin and unattached to it. If located in the abdominal wall near the bony pelvis, it may seem to be attached to bone as in the case described below. It is most important to palpate the growth when the abdominal muscles are tightly contracted, as well as when they are relaxed. This maneuver, known as Bouchacourt's sign, readily differentiates intra-abdominal tumors and those within the abdominal wall itself. When the abdominal muscles are contracted (the patient is asked to sit up from a recumbent position), an intra-abdominal mass becomes indistinct, while a mass within the wall becomes more prominent. These tumors tend to be freely movable only in a direction at right angles to the course of the muscle to which they are attached. In the opposite plane they are fixed.

Differential Diagnosis

In the differential diagnosis several other conditions must be kept in mind. Intra-abdominal tumors such as uterine fibroid, ovarian tumor, and carcinoma of the cecum, which has become attached to the anterior abdominal wall, must be ruled out. Certain tense hernias, particularly interstitial and incisional hernias, may simulate desmoid tumors, especially if they are of long standing and contain incarcerated omentum rather than bowel. Arising from the bony pelvis, tumors such as chondroma, fibrosarcoma, and osteogenic sarcoma may invade the abdominal wall and give the appearance of a desmoma. Finally, tumors within the abdominal wall itself, fibroma, neurofibroma, keloid, and lipoma may only be differentiated after surgical removal.

Treatment

The ideal treatment of desmoid tumors is surgical excision. It must be stressed that complete removal, with a wide margin of normal tissue on all sides of the growth, is necessary. One reason for the high recurrence rate is the difficulty experienced in identifying and removing the infiltrating margins of the tumor. The practice of tumor enucleation, as is done in well-encapsulated growths, is to be particularly avoided in suspected desmomas.

In large tumors adequate incision may result in extensive defects in the anterior abdominal wall, including loss of peritoneum. Because of laxity of the abdominal wall in parous females, most such defects may be closed without undue tension; however, it may be necessary to use fascial transplants or flaps in some instances.

The experience of most authors is that radiation therapy is of little benefit; yet the more recent work at Memorial Hospital indicates that both x-ray and radium have a definite place in the treatment of desmoid tumors. Surgery is clearly the ideal treatment; however, definite value can be obtained from irradiation in inoperable cases, in poor risk patients, and in those patients who refuse operation. Since desmomas in males are known to be radioresistant, irradiation is recommended only in females.

Castration and hormonal therapy are interesting from a theoretical standpoint, but little experience in their actual use has been recorded. Pack warned

against further childbearing because of the likelihood of recurrence during pregnancy. In view of the essentially benign nature of this tumor,. this advice may seem somewhat overcautious.

Report of Case

A 26 year old female was first seen on Dec. 14, 1951, complaining of a mass in the lower abdomen. The tumor was accidently discovered four days previously and had caused no pain, tenderness, or other symptoms. The patient sought medical advice because of concern about the nature of the lesion. Nine months previously, after an uneventful pregnancy, the patient had borne her first child.

The patient's past history was negative for illnesses and injuries. The general physical examination was negative except for rather marked lumbar scoliosis.

The abdomen was scaphoid and the abdominal wall was thin. Just medial to the anterior superior iliac spine there was an oval mass 3 to 4 cm. in its longest diameter. The mass was smooth in outline and hard. It seemed to arise close to the ilium, although it was movable. There was no tenderness. When the abdominal muscles were contracted, the nodule became more prominent. The overlying skin appeared normal and was unattached to the tumor. There were no intra-abdominal masses, and pelvic examination was negative. There were a few normal lymph nodes in both inguinofemoral areas.

Routine laboratory examinations were normal.

A tentative diagnosis of fibroma, or osteochondroma, was made and operation was advised.

On Dec. 15, 1951, operation was carried out under general anesthesia. A transverse incision was made directly over the lesion. The fibers of the external oblique were divided, and the internal oblique muscle in which the tumor lay was exposed. No further effort was made to expose the mass for fear of encroaching upon the margins of the growth. Block resection of the tumor was carried out, with the removal of a wide margin of normal internal oblique and transversus abdominus muscles. The peritoneum was uninvolved and was left intact. There was no attachment of the growth to the bony pelvis. The muscle and fascial defect was closed under moderate tension with interrupted cotton sutures.

The report by Dr. E. L. Schafer, pathologist, showed that grossly the specimen consisted of a roughly ovoid mass 3.5 by 2.5 by 2 cm. A layer of muscle covered the specimen. Section showed a well-circumscribed but non-encapsulated mass of firm, pale, grayish-pink tissue irregularly transversed by interlacing white fibrous bands. Microscopically the sections showed a relatively well-circumscribed tumor, which seemed to be arising from the fascia and skeletal muscle. Many degenerating muscle fibers were incorporated in the tumor at its periphery. Young, immature fibroblasts formed the bulk of the mass. The spindle-shaped cells with plump, vesicular nuclei were arranged in a whorled pattern. Throughout there were numerous small capillaries and blood vessels. There was evidence of recent hemorrhage along one margin, and in this vicinity there were collections of giant cells and small lymphocytes.

Recovery from the operation was uneventful, and the wound healed *per primam.* When the patient was last seen six months following operation, there was no evidence of recurrence.

Summary

Desmoid tumor is a benign fibrous tissue growth occurring most commonly in the abdominal wall of parous women.

The cause of this tumor appears to be muscle trauma due to labor, accident, or operation. Hormonal factors may play a role in the development of these growths.

Although distant metastases do not occur, this tumor is locally invasive and shows a great tendency to recur after surgical removal.

Ideal treatment is wide excision. In inoperable cases radiation therapy produces slow regression of the tumor.

A typical case is presented of a desmoid tumor arising in a young woman nine months after the birth of her first child.

REFERENCES

1. Brockman, D. D.: Congenital desmoid of the abdominal wall, J. Pediat. 31:217–219 (Aug.) 1947.
2. Geschickter, C. F., and Lewis, D.: Tumors of connective tissue, Am. J. Cancer 25:630–655 (Nov.) 1935.
3. Green, C. C.: Desmoid tumor, Arch. Surg. 50:304–306 (June) 1945.
4. Macfarlane, J.: Clinical reports of the surgical practice of the Glasgow Royal Infirmary. Glasgow, D. Robertson, 1832, pages 63 and 66.
5. Mueller, J.: Ueber den feinern Bau und die Formen der krankhaften Geschwuelste, Berlin, 1838.
6. Pack, G. T., and Ehrlich, H. E.: Neoplasms of the anterior abdominal wall with special consideration of desmoid tumors; experience with 391 cases and a collective review of the literature, Internat. Abstr. Surg. 79:177–198 (Sept.) 1944.
7. Pearman, R. O., and Mayo, C. W.: Desmoid tumors; a clinical and pathologic study, Ann. Surg. 115: 114–125 (Jan.) 1942.
8. Stewart, M. J., and Mouat, T. B.: Fibroma of the abdominal wall, Brit. J. Surg. 12:355–377 (Oct.) 1924.

16 South Henry Street.

MARQUETTE ALUMNI WILL HOLD ANNUAL SPRING CLINIC

Members of the Marquette University School of Medicine Alumni Association will sponsor their annual Spring Clinic at the medical school on March 28.

The program will feature a nationally known speaker on diagnosis and treatment of cancer, medical and surgical sectional meetings, the report of a Korean veteran alumnus on war medicine, and presentation of the annual Alumni Award. An informal dinner dance at the Wisconsin club has been scheduled for the evening.

The Treatment of Acute Leukemia With Combined Steroid Hormones and Folic Acid Antagonists*

By G. E. MAGNIN, M. D., ROYAL ROTTER, M. D., and OVID O. MEYER, M. D.
Marshfield Madison

WITHIN the past five years new hope has been given to the patient with acute leukemia by the development of two agents which have been shown to influence the course of the disease in some patients. Using the *folic acid antagonists*, Farber[1] has shown a total improvement rate of 54.6 per cent in a series of 238 consecutive, unselected patients with acute leukemia. Wilson[2] observed 65 patients treated for acute leukemia with folic acid antagonists and noted excellent clinical and hematologic remissions in 11, while a partial remission occurred in 19 subjects. In general, from the experience of others throughout the country, about 50 per cent of unselected children have shown important improvement with these preparations, although many experimenters report less favorable results.[1] The *steroid hormones, cortisone and corticotropin*, have also shown promise in the treatment of acute leukemia. Rosenthal, *et al.*,[3] observed that, of 13 patients with acute or subacute lymphocytic leukemia, 9 (69 per cent) developed objective and hematologic evidence of well-defined remissions. These remissions, however, were brief and were followed by a relapse when the therapy was discontinued. Of 5 patients with acute granulocytic leukemia only one showed a slight clinical improvement with therapy. Two cases of monocytic leukemia showed no response, and death seemed to be hastened. Others have observed a similar response to steroid hormones.

The use of steroid hormones and folic acid antagonists in the same patient with acute leukemia has been suggested by Pillers, *et al.*[4] These workers tried one of these preparations and reserved the use of the other for a failure of continued response to the first. Their observations indicated that steroid hormones or folic acid antagonists were effective in producing further remissions in approximately 50 per cent of patients showing resistance to one type of therapy. The fact that a high percentage of patients responded to hormone or antifolic acid therapy at a late stage in the course of the disease, when there had developed resistance to the other type of treatment, suggested that corticotropin and cortisone have a different primary mode of action on the leukemic process from that of the folic acid antagonists.

With the hope that these two compounds might potentiate each other and thereby produce a complete and prolonged clinical and hematologic remission, we treated 17 patients at the University Hospitals in Madison, Wisconsin, with combined hormone and antifolic acid therapy.

Methods: Seventeen patients admitted to the University Hospitals with a diagnosis of acute leukemia between January 1951 and May 1952 were treated with a combination of antifolic acid therapy and steroid hormone. No attempt was made to exclude critically ill and obviously terminal patients.

Complete blood counts were performed on all patients upon admission to the hospital before therapy was instituted. Erythrocytes and leukocytes were enumerated by conventional methods, and hemoglobin determinations were made in a photoelectric colorimeter. A 500 cell differential blood count was performed in all cases. Platelets were not counted but were estimated from the blood smears as being scanty, present in normal numbers, or increased. Bone marrow specimens were obtained by aspiration from the sternum, iliac crest, or tibia; and 500 cells were counted from the direct smear.

Following initiation of therapy, hemoglobin and leukocyte counts were made every other day, or more often, until a satisfactory response was obtained. A complete blood count and platelet estimation was performed at weekly intervals.

Reticulocyte counts were performed initially, but it was soon apparent that platelet estimation was a more reliable guide to hematologic response, and this procedure was abandoned as a routine procedure.

Progress marrow studies were obtained whenever the clinical picture warranted their being done. This study was not used as a routine guide to therapy.

For the sake of comparison we elected to review the records of all the patients with acute leukemia who were treated at the hospital with Aminopterin and supportive measures.

Aminopterin Treated Group

A series of 12 patients with acute leukemia were treated with Aminopterin between 1948 and 1951. Five were females, and 7 were males. Their ages ranged from 2 months to 35 years.

The initial complaints of these patients were variable and included the following: upper respiratory infection with fever, shortness of breath, "black and blue spots," easy fatigue, localized lymph node swelling, migratory joint pain, weakness, and pallor.

The physical findings appeared to be quite consistent; all the patients had pallor, generalized lymphadenopathy, and hepatomegaly. In all but two in-

* From the Department of Medicine, University of Wisconsin Medical School. The Aminopterin used in these studies was kindly supplied by Dr. J. M. Ruegsegger of Lederle Laboratories.

stances the spleen was palpably enlarged, and in one patient it extended into the pelvis. Hemorrhagic manifestations became apparent at some time in the course of the illness in all but one patient. Petechiae and ecchymoses occurred most frequently, but in five of the series massive gastrointestinal hemorrhage developed terminally. Epistaxis, bleeding gums, renal bleeding, and retroperitoneal hemorrhage were also observed.

Laboratory Studies: In all instances the leukemia was of the acute lymphocytic variety. Every patient was anemic, and in most cases the anemia was normochromic and normocytic. The initial hemoglobin values varied from 3.7 to 12.0 Gm., and the erythrocyte count varied from 1,100,000 to 3,900,000. In every instance there was evidence of leukocytosis, varying from 17,900 to 500,000. The predominant cells in all the differential counts were blasts, pathologic cells just beyond the blast stage, and lymphocytes in various stages of development. The number of blast cells present in the initial smear varied from 5 to 47 per cent.

The platelets were estimated from the blood smear as being scanty or absent in every case. Basket cells were numerous. Sternal marrow studies were performed in 6 of the 12 patients, and again the predominant cells were blasts, pathologic cells just beyond the blast stage, and lymphocytes. The number of blast cells present in the marrow varied from 14.6 to 70.0 per cent.

X-ray studies demonstrated the presence of mediastinal lymphadenopathy in 3 cases and bone involvement in only one.

General Treatment: Blood transfusions were administered at variable intervals and in varying quantities to all patients during their hospitalization. Antimicrobial agents, particularly penicillin, were used freely to combat associated infection. X-ray therapy was used in 3 instances: in one patient it was directed to the chest in an attempt to reduce lymph node obstruction to venous return; in another to a markedly enlarged spleen that was causing pressure symptoms; and in the third to a lesion in the femur that was mistakenly diagnosed as a localized tumor. One patient received protamine for the purpose of combating hemorrhagic manifestations attributed to hyperheparinemia. Cortisone was administered to another patient for a period of 19 days before Aminopterin therapy was instituted. The response was not favorable. The patient is included with this series because the cortisone and Aminopterin were not given simultaneously.

Mode of Administration and Dose of Aminopterin: All 12 of the patients received Aminopterin for variable periods of time during the course of their illness. The medication was administered intramuscularly to 7 patients, orally to 4 patients, and sequentially by both routes to 1 patient. The dosage varied from 0.25 to 2.0 mg. per day, with an average of about 1.0 mg. per day. Adjustment of dosage depended upon the clinical response and the appearance of toxic manifestations. The total duration of treatment for any one patient varied between 4 and 79 days, with an average of 22 days.

Clinical Response: General improvement in well being was noted in seven instances, but it was always short-lived except for one case. The one patient who was treated for 79 days experienced a remission of 4 months with a marked decrease in the size of his liver and spleen; but he then died at home following a massive gastrointestinal hemorrhage. The remissions in the other patients only lasted a few days to a few weeks. Two of these patients demonstrated a decrease in size of their liver, spleen, and lymph nodes. Increased cheerfulness and a return of appetite were the most common signs of improvement, although the disappearance of fever, bleeding manifestations, and joint pain was also noted. Five patients failed to show favorable response, and the disease progressed rapidly to death despite continued treatment.

Laboratory Response: From the laboratory standpoint, there was only one remission, and this was in the same patient who obtained the best clinical remission. At the height of the remission the diagnosis of leukemia could not be made from the peripheral blood smear. The platelets increased from practically none to a normal level; the hemoglobin and erythrocyte count attained the normal range; and the leukocyte count dropped from 284,000 to 7,200, with a disappearance of all blast cells and an increase of the neutrophils to 52 per cent. The most consistent laboratory finding associated with the Aminopterin therapy was the marked fall in the total leukocyte count, at times assuming dramatic proportions. In one instance the white blood cell count decreased from 217,000 to 1,200 in 6 days and in another instance from 500,000 to 16,000 after 17 days of treatment. Some blast cells persisted in all cases except one, although decrease in number was the rule. The neutrophilic increase was unimpressive, and the platelets remained low despite therapy. The erythrocyte count and hemoglobin showed no improvement.

Toxic Reactions: The toxic reactions to Aminopterin were difficult to evaluate because in many respects they simulated the clinical signs of acute leukemia. Hemorrhagic manifestations, for example, may be associated with the primary illness or may result from mucosal ulcerations produced by the Aminopterin. In this series of 12 patients, bleeding appeared or became increased in 8 during or immediately after the course of Aminopterin therapy. Five of the patients bled from the gastrointestinal tract, the other 3 bled from the gums, kidneys, lungs and into the skin. Ulceration of the buccal mucosa in one patient disappeared when therapy was stopped. Alopecia was not seen in this series.

Necropsy Findings: Two of this series of 12 patients were discharged from the hospital, and no follow-up report is available. Their condition upon discharge was poor. Of the 10 remaining patients,

TABLE 1—*Summary of 12 Patie*

Patient	Sex	Age (Yr.)	Laboratory				Diagnosis*	Supportive
			Hemoglobin (Gm.)	White Blood Cells (10^3)	Differential (%)	Bone Marrow (%)		
1. C.B.	F	8	7.3	88.8	25.6 BLASTS 57.6 PATH. LYMPHS.	NONE	A.L.L.	Transfusions Penicillin
2. B.E.	M	1	12.0	86.0	5.0 BLASTS 10.0 PATH. CELLS 57.0 ATYPICAL LYMPHS.	NONE	A.L.L.	Transfusions 6 deep x-ray treat ments to chest Liver extract
3. G.J.	M	2	4.7	66.3	7.8 BLASTS 20.2 SMALL LYMPHS. 20.2 ATYPICAL LYMPHS. 19.4 PATH. LYMPHS. 14.4 YOUNG LYMPHS.	34.8 PATH. CELLS 22.0 BLASTS 28.1 ATYPICAL LYMPHS.	A.L.L.	Transfusions 5 deep x-ray treat ments to spleen
4. A.F.	F	1/6	7.9	316.5	26.8 BLASTS 30.2 PATH. CELLS 26.4 PATH. LYMPHS.	NONE	A.L.L.	Transfusions Cortisone for 19 d Aminopterin
5. D.S.	M	14	7.7	500.00	47.0 BLASTS 48.0 YOUNG LYMPHS.	NONE	A.L.L.	Transfusions Protamine
6. W.S.	M	22	6.2	85.0	30.2 BLASTS 20.8 PATH. CELLS 29.0 PATH. LYMPHS.	13.6 PATH. CELLS 13.0 PATH. LYMPHS. 69.6 BLASTS	A.L.L.	Transfusions
7. J.S.	M	5	8.5	136.4	17.0 BLASTS 16.4 PATH. CELLS 21.2 SMALL LYMPHS. 17.0 PATH. LYMPHS.	NONE	A.L.L.	Transfusions Penicillin Sulfadiazine
8. J.V.	F	1	7.0	295.0	25.0 BLASTS 59.0 PATH. LYMPHS. 10.0 YOUNG LYMPHS.	NONE	A.L.L.	Transfusions Penicillin
9. D.V.	F	2	6.0	34.0	33.2 BLASTS 7.0 PATH. CELLS 25.0 PATH. LYMPHS.	70.0 BLASTS 11.0 LYMPHS.	A.L.L.	Transfusions
10. J.W.	F	2	11.0	17.9	20.0 BLASTS 12.4 PATH. CELLS 12.6 ATYPICAL LYMPHS.	1.8 BLASTS 7.5 PATH. CELLS 22.0 ATYPICAL LYMPHS. 15.0 SMALL LYMPHS.	A.L.L.	Transfusions Deep x-ray therap to hip
11. R.W.	M	35	12.0	57.2	19.2 BLASTS 48.4 PATH. CELLS 11.0 YOUNG LYMPHS.	58.0 BLASTS 13.6 PATH. CELLS 12.0 LYMPHS.	A.L.L.	Transfusions
12. R.W.	M	3	3.7	129.5	5.0 BLASTS 15.6 PATH. CELLS 22.0 PATH. LYMPHS. 33.6 SMALL LYMPHS.	14.6 BLASTS 10.2 PATH. CELLS 66.4 PATH. LYMPHS.	A.L.L.	Transfusions

*A.L.L. = acute lymphocytic leukemia.

2 died shortly after they left the hospital, and necropsies were not performed. Postmortem examinations were made in 6 of the 12 patients.

Generalized lymphadenopathy with lymphatic infiltration into the liver, spleen, and bone marrow was noted in every case. The findings were compatible with the diagnosis of acute lymphocytic leukemia. Ulcerations of the ileum were demonstrated in 2 patients, and massive gastrointestinal hemorrhage was noted in 2 other patients. Another patient died with hemorrhage into the renal pelves and into the retroperitoneal space. Terminal septicemia with bacterial infarcts in the various body organs were found in 2 additional patients.

Combined Aminopterin–Steroid Hormone Treated Group

Since January 1951, a total of 17 patients have been treated with a combination of Aminopterin and steroid hormones. Of this number, 5 were female and 12 were male. Their ages ranged from 3 months to 53 years. The initial complaints and clinical findings in 16 of these patients did not differ markedly from the Aminopterin treated group. One patient's illness was ushered in with a left facial paralysis due to a subdural hematoma. Pallor, lymphadenopathy, hepatomegaly, splenomegaly, and hemorrhagic manifestations were present in almost every instance.

Laboratory Studies: Of this series 14 cases were acute lymphocytic, one was acute monocytic, one was granulocytic, and one was in an acute phase of a chronic lymphocytic leukemia.

In general the laboratory studies were quite similar to the Aminopterin treated group. On admission there was a maximum variation of hemoglobin value from 3.5 to 12.5 Gm., and the erythrocyte count varied from 1,100,000 to 4,100,000. Three of this series were leukopenic on admission, with a leukocyte count below 5,000 cu. mm. Six had an initial leukocyte count of over 150,000. One value was reported as 685,000. Again, as in the first group,

ated with Aminopterin

Therapy				Duration of Life After Therapy Started (Months)	Remarks
ration of inopterin herapy Days)	Clinical Response	Laboratory Response	Toxic Reaction		
24	POOR	WBC fell to 2.6 Blasts persisted	NONE	2	Died at home shortly after discharge; no autopsy.
38	POOR	WBC fell to 3.7 Immature cells persisted	Massive hematemesis	1½	Autopsy showed G.I. ulceration and hemorrhage. Infiltration in liver and spleen. Leukemic bone marrow.
96	GOOD	WBC fell to 7.2 All immature cells disappeared 52% mature neuts. appeared	Hematemesis	6	Died at home. No autopsy.
10	POOR	WBC fell to 1.2	Hematemesis and melena	1	Autopsy showed ulceration and hemorrhage in large bowel. Terminal septicemia with bacterial infarcts in lung, kidney, and intestine.
18	POOR	WBC fell to 16.0	Massive hematemesis and melena	1	Autopsy showed massive G. I. hemorrhage. Renal and pulmonary hemorrhage. Generalized anasarca. Leukemic infiltration.
12	POOR	WBC fell to 6.7 Blasts persisted but decreased	Bleeding gums	½	Autopsy showed lymphoid infiltration of liver and spleen. Terminal septicemia with septic infarcts in lung and kidney.
4	POOR	WBC fell to 68.4 Blasts decreased slightly	Hematuria	1/8	Autopsy showed retroperitoneal hemorrhage and hemorrhage into renal pelves. Lymphoid infiltration into spleen and liver.
30	FAIR	WBC fell to 1.8 Young forms decreased to 6% Neuts. increased to 21%	NONE	1	Autopsy showed some lymphoid infiltration of spleen and liver. Ulcerations of ileum.
11	POOR	WBC fell to 4.0	NONE	1/3	Continued to decline and expired in the hospital. No autopsy.
10	FAIR	WBC fell to 14.0 Blasts disappeared	Bleeding from lips and hematemesis	1½	Patient was discharged from hospital in poor condition, and no follow-up report is available.
13	POOR	WBC continued to rise to 336.0 Hgb fell despite transfusions	NONE	1/3	Rapid deterioration to death, despite therapy. No autopsy.
21	FAIR	WBC fell to 3.5 Immature cells persisted in blood and marrow	NONE	1	Patient was discharged from hospital and no follow-up report is available.

the predominating cell was the blast or pathologic cell just beyond the blast stage. In all the patients, except for some with leukopenia, blast cells or other early forms predominated. In those with leukopenia the diagnosis depended upon sternal marrow study.

The platelets again were estimated from the smear of the peripheral blood and were found to be markedly reduced or absent in every case. Bone marrow specimens were procured in 15 of the 17 patients. In all instances there was marked reduction in megakaryocytes and red blood cell precursors, with a predominance of primitive leukocytes.

Three children demonstrated roentgen changes compatible with leukemic involvement of the bones.

Therapy: (a) The same supportive measures were used in this group as in the Aminopterin treated group. Antibiotic therapy was routine in this series. Aureomycin was purposefully avoided because of its antagonism to Aminopterin. Two patients received protamine sulfate for bleeding.

(b) Aminopterin and steroid hormone therapy: The method of administration varied with each individual but, basically, both adults and children received 0.5 mg. of Aminopterin from 4 to 7 days in order to determine sensitivity. The drug was then either increased to 1.0 mg. daily or reduced to 0.25 mg. daily, depending upon the response. It was continued for a minimum of 21 days unless untoward effects intervened.

Concomitantly, the children received 25 mg. of cortisone every 8 hours for one week; 25 mg. every 12 hours for the second week; and 25 mg. daily for the third week. The drug was then discontinued. Adults received a schedule consisting of 100 mg. of cortisone three times daily for three days, followed by a reduction of 25 mg. daily until they were receiving 25 mg. daily. They were maintained on cortisone for three weeks, after which time the drug was discontinued. Corticotropin was employed in two children and was administered according to the same dosage schedule as cortisone.

Clinical Response: Except for one patient, all of this group experienced subjective improvement. The single exception was a three month old white female

Table 2—Summary of 17 Patients Treated i

Patient	Sex	Age (Yr.)	Laboratory				Diagnosis*	Supportive
			Hemoglobin (Gm.)	White Blood Cells (10^3)	Differential (%)	Bone Marrow (%)		
1. E.G.	M	19	7.0	14.4	17.2 BLASTS 46.8 PATH. CELLS 38.8 LYMPHS.	21.4 BLASTS 49.0 PATH. CELLS MEGAKARYO. LOW	A.L.L.	I. and D. of nec abscess Antibiotics Protamine
2. P.H.	F	4	3.7	431.3	14.2 BLASTS 35.0 PATH. CELLS 20.2 MONOS.	32.2 BLASTS 27.9 PATH. CELLS 0.5 NORMOBLASTS	A.L.L.	I. and D. absces neck and axill Transfusions Antibiotics
3. M.K.	M	2	4.8	13.7	6.0 BLASTS 53.3 LYMPHS. 15.3 MONOS.	NOT SATISFACTORY	A.L.L.	Antibiotics Transfusions
4. R.K.	M	13	5.0	22.4	14.0 BLASTS 13.2 MONOS. 40.4 PROMONOS.	34.4 BLASTS 47.6 IMMATURE CELLS AUER BODIES	A.M.L.	Transfusions
5. D.L.	M	2	6.8	96.2	36.8 BLASTS 37.5 PATH. CELLS 15.4 LYMPHS.	49.0 BLASTS	A.L.L.	Transfusions
6. M.M.	F	¼	6.9	685.7	63.0 BLASTS 10.5 PATH. CELLS 7.8 LYMPHS.	NOT DONE	A.L.L.	None
7. D.M.	M	3	12.5	2.1	78.8 LYMPHS. 14.0 NEUTS.	4.7 BLASTS 33.7 PATH. CELLS 3.5 LYMPHS.	A.L.L.	Transfusions Penicillin X-ray to spleen
8. M.M.	F	2½	3.7	150.0	29.2 BLASTS 42.2 PATH. CELLS 24.4 LYMPH.	14.3 BLASTS 71.5 PATH. CELLS	A.L.L.	Transfusions Penicillin
9. L.S.	F	22	11.0	110.0	0.6 BLASTS 11.6 PATH. CELLS 58.4 LYMPHS.	6.0 BLASTS 26.6 PATH. CELLS 24.4 LYMPHS.	A.L.L.	X-ray to long bo Transfusions
10. J.W.	M	3	3.5	185.0	60.0 BLASTS 14.5 PATH. CELLS 10.4 NEUTS.	57.8 BLASTS 5.9 PATH. CELLS	A.L.L.	Antibiotics
11. L.S.	M	53	7.5	222.0	71.4 BLASTS	84.6 BLASTS	Acute phase of chronic L.L.	Antibiotics Transfusions
12. S.W.	M	1/3	11.5	4.8	11.2 NEUTS. 85.8 LYMPHS. 2.3 PATH. CELLS	NOT DONE	A.L.L.	Antibiotics
13. R.H.	M	2	7.6	1.4	76.0 LYMPHS. 14.4 ATYPICAL CELLS	NOT DONE	A.L.L.	Antibiotics Transfusions
14. K.M.	F	39	7.2	79.0	70.0 BLASTS 15.0 LYMPHS.	2.3 BLASTS 29.3 PATH. CELLS	A.L.L.	Protamine Antibiotics Transfusions
15. W.K.	M	2	8.0	4.53	88.0 LYMPHS. 9.0 NEUTS.	0.6 BLASTS 76.8 PATH. CELLS 16.3 ATYPICAL LYMPHS.	A.L.L.	Transfusions Antibiotics
16. M.D.	M	19	8.0	308.0	26.0 BLASTS 68.0 LYMPHS.	56.3 BLASTS 35.3 PATH. CELLS	A.L.L.	Penicillin Transfusions
17. J.B.	M	32	9.8	99.0	85.0 BLASTS AUER BODIES	40.0 BLASTS	A.G.L.	Antibiotics Transfusions

*A.L.L. = acute lymphocytic leukemia. A.M.L. = acute monocytic leukemia. A.G.L. = acute granulocytic leukemia.

who expired from a subdural hemorrhage two days after the initiation of therapy.

The most striking evidence of improvement consisted of a general sense of well-being, associated with a fall in temperature. This was usually apparent in from 24 to 48 hours after the initiation of therapy. Other signs of improvement included an increase in appetite, interest in the environment, and an increase in strength. In 9 of 17 patients there was a definite decrease in the size of the spleen, and in 6 of this group it could no longer be palpated. This was usually associated with a regres-

bined Folic Acid Antagonists and Steroid Hormones

Therapy				Duration of Life After Therapy Started (Months)	Remarks
ation of mbined herapy Days)	Clinical Response	Laboratory Response	Toxic Reaction		
opterin isone 21	GOOD	Hgb 15.2 Gm. WBC 7.4 Platelets normal 75% Neuts.	Stomatitis Epistaxis Cellulitis of neck	13	Four relapses and prompt remission with addition of cortisone. Autopsy: G.I. bleeding.
opterin T.H. 21	GOOD	Hgb 12.75 Gm. WBC 5.7 57% Neuts. Retics. 13% Marrow: Erythroid hyperplasia	Abscess formation	6	Initially suggested a monocytic leukemia but terminated as given. Autopsy: G.I. hemorrhage.
opterin isone 21	POOR	Hgb 5.2 Gm. WBC 1.0 Platelets absent	Platelet reduction	1	Failure may be attributed to aminopterin toxicity with platelet suppression on this basis. Autopsy: General hemorrhage.
isone opterin 5	POOR	WBC increased to 60,000	NONE	¼	Inadequate test of therapy. Died of subdural hemorrhage. (Autopsy)
opterin isone 10	POOR	Platelets absent Not remarkable	Stomatitis G.I. bleeding	½	Termination—Massive G. I. bleeding.
opterin isone 3	POOR	Not remarkable	NONE	1/6	Inadequate trial of therapy. Autopsy: Hematoma, intracranial.
opterin isone 21	GOOD	Hgb 12.9 Gm. RBC 4.40, WBC 5.5 55% Neuts. Platelets normal	G.I. bleeding Alopecia	14	Still living but splenomegaly and general lymphadenopathy is now present.
opterin T.H. 20	FAIR	WBC 3.8 17% Neuts. Platelets low normal	Stomatitis	4½	Disease process modified but child was never in state of remission.
opterin isone 14	POOR	WBC 11.25 Lymphs 98.8%	NONE	2	No autopsy.
opterin sone 21+	GOOD	Platelets increased Hgb 11.6 Gm. WBC 5.8 58% Neuts.	Moon face Alopecia Stomatitis	5	Short remission. Marked adenopathy terminally.
opterin sone 16	POOR	Platelets absent WBC fell to 300/mm	DEATH	½	Patient responded initially. Believe death due to therapy. No evidence of leukemia at autopsy.
hopterin 10 sone 13 opterin 3	POOR	WBC 1.6	NONE	1	Received amethopterin 1.25 mg. daily for 10 days. Then placed on aminopterin. Autopsy: G.I. bleeding.
T.H. opterin 21	GOOD	Hgb 12.75 Gm. WBC 8.3 Neuts. 58.4 Platelets increased	Cellulitis of scalp Edema	11	Received A.C.T.H. for 5 days. Discontinued because of moon facies and infection. Autopsy.
opterin sone 21	GOOD	Hgb 15.0 Gm. WBC 2.2 Platelets normal	Stomatitis	6	Died following short remission from G. I. hemorrhage. Autopsy.
opterin sone 21	GOOD	Hgb 12.5 Gm. WBC 10.0 56% Neuts. Platelets increased	Stomatitis	7	Expired at home after a brief but excellent remission.
opterin sone 21	GOOD	Platelets normal	NONE	2	Dramatic response initially with prompt relapse and death from intracranial bleeding.
opterin sone 21	POOR	No response	Stomatitis	4	Autopsy: Leukemic infiltration of urinary tract.

sion of the hepatomegaly and lymphadenopathy. These objective changes ordinarily became manifest from the tenth to the seventeenth day after treatment was initiated. Bleeding manifestations tended to disappear during this interval.

Laboratory Response: For the purpose of this discussion we have defined a hematologic remission as consisting of (1) a return of the platelets to normal, (2) maintenance of a normal erythrocyte count and hemoglobin value, (3) a return of the white blood cell count to a normal level and persistence at this level, and (4) a trend toward normalization of the differential leukocyte count with the presence of at least 30 per cent neutrophils and

a reduction of the abnormal forms to 1 per cent or less.

According to these criteria, 8 of the 17 patients experienced a hematologic remission for from 2 weeks to 14 months. An additional patient showed clinical evidence of response but only a partial hematologic remission. We believe that the earliest laboratory evidence of a remission is an increase in the reticulocytes, which is usually apparent between the fifth and the fifteenth day of therapy.

It was our experience that an estimation of the platelets in a peripheral blood smear offered the easiest method of evaluating the hematologic response. In every instance of clinical remission the platelets returned to normal or high normal levels, and with this there was a subsidence of the hemorrhagic tendency.

In all of the lymphocytic leukemias in this series there was a return of the white blood cell count toward normal in 48 to 96 hours. This was not observed in the monocytic and granulocytic group.

An example of the prompt response may be cited. In one 19 year old male the leukocyte count fell from 308,000 to 1,400 in a period of one week. From a prognostic standpoint the fall of a high leukocyte count toward normal, or below, means little inasmuch as it was not always paralleled by clinical and other hematologic responses. Actually the fall may be a toxic manifestation of the treatment, and it is often extremely difficult to differentiate a toxic from a therapeutic response early in the course of treatment.

Although it would have been ideal to follow the patient's progress with marrow studies, this was not always feasible. In the patients in which progress marrow studies were performed, the changes preceded those in the peripheral blood.

Toxic Manifestations: Again, it was difficult to dissociate the toxic manifestation of the drugs from the clinical signs of the disease. The most commonly observed finding was that of stomatitis; 7 patients exhibited this. Discontinuance of the drug usually was followed by disappearance of the oral ulcerations. Bleeding from the nose, mouth, gastrointestinal, and renal systems was frequently observed while the patients were receiving the combined therapy, but we were uncertain as to whether this was drug-induced or a manifestation of the disease. Alopecia was observed in two instances, but hair growth returned when the dosage of Aminopterin was decreased.

Results of Therapy: At the time of this writing (October 1952) only 1 of the 17 patients in this series was still living. This patient was treated in the usual manner with combined therapy and was maintained on 0.25 mg. of Aminopterin 5 days of each week. He was started on therapy in April 1951, after the diagnosis of acute lymphocytic leukemia, leukopenic type, was established by lymph node biopsy and sternal marrow aspiration. When last seen early in June 1952, there was evidence of recurrence of his disease as exemplified by anemia and splenomegaly. Prior to this time he had led the life of a normal 3 year old child.

Of the remaining 16 patients, 14 expired in this hospital. One exception was a 2½ year old white female who experienced a transient clinical remission but who was in a state of relapse and appeared to be terminal when her parents insisted on taking her home. The other expired at home following an excellent seven month's remission. Of the 14 patients who expired in the hospital, the average duration of life was 3.8 months after the institution of therapy. Of the group of 9 patients who exhibited a satisfactory response to this treatment, the average duration of life following initiation of therapy was 7.4 months as opposed to the refractory group of 8 patients whose average duration of life was only 1.1 month following institution of therapy.

Modes of Death and Autopsy Findings: Eleven of the 14 patients who expired while in the hospital had postmortem examinations. Seven patients died from massive gastrointestinal hemorrhage, 3 from intracranial hemorrhage, and 1 from a combination of renal and gastrointestinal bleeding plus a necrotizing pharyngitis and pneumonia.

With the exception of one patient, all of this group exhibited the characteristic pathology of leukemia; namely, infiltration of the liver and spleen, generalized lymphadenopathy, and hemorrhagic manifestations. The single exception was that of a 53 year old white male who had an acute phase of a chronic lymphocytic leukemia and who expired from a massive gastrointestinal hemorrhage three weeks after the initiation of combined therapy. At autopsy there was no evidence of leukemia. The cause of death was thought to be due to mucosal ulceration secondary to the therapy—either the Aminopterin, the cortisone, or a combination of the two. The diagnosis was firmly established during life by marrow and peripheral blood studies.

Of the 3 patients who did not have autopsies performed, 2 died of gastrointestinal bleeding and the third expired from an overwhelming infection.

Discussion

Prior to 1947 the prognosis for acute leukemia was uniformly poor, with death occurring usually within four months following the diagnosis. However, Diamond[1] reviewed the histories of 300 children with acute leukemia seen at the Childrens' Hospital in Boston in the 25 years prior to 1947 and approximately 10 per cent of those patients had so-called spontaneous remissions. This figure is probably somewhat higher than the figure for the country as a whole. About 75 per cent of Diamond's group with so-called spontaneous remissions had important degrees of infection present just prior to the onset of the remission. This factor of spon-

taneous remission must be evaluated when any analysis of therapeutic measures is made.

We have already established our criteria for a hematologic remission and have classified the response of all patients as either good, fair, or poor. (See tables) By good, we infer a hematologic remission plus the disappearance of the clinical manifestations of the disease. By poor, we mean those patients who showed no real hematologic or objective clinical improvement. A fair response indicated some favorable alteration of the disease process but persistence of the disease manifestations.

By any criteria there seems to be little doubt that supportive measures such as blood transfusions and antibiotics have prolonged the lives of many patients with acute leukemia; but the outcome has been uniformly fatal. The antifolic acid compounds have improved the prognosis and have induced clinical and hematologic remissions in as many as 50 per cent of the treated subjects, according to Farber.[1] This is not a cure, but the very fact that some agent is able to alter the course of a fatal disease is encouraging.

Our own experience with Aminopterin has not been good. Since several of the patients were terminal when therapy was instituted and since treatment was continued for only a short period in most instances, it is not surprising that but 1 out of 12 patients survived longer than two months. Only 5 in this series of patients were treated for three weeks or longer, so an evaluation is difficult. Although just one patient had his life significantly prolonged, almost all demonstrated some interference with the basic pathologic mechanism of the leukemic process.

With combined antifolic acid and steroid hormone therapy, the results were much more favorable. According to the established criteria, 8 patients obtained a good response, 8 a poor response, and 1 a fair response. One patient in this series of 17 is living at the time of this writing, 14 months after the initiation of therapy. A total of 6 patients in this group survived for six months or longer after therapy was started. Of the six adults treated there was a good response in three, although of the three the remission was prolonged in duration in but one. In a single instance it was thought that death was due to drug toxicity, since there was no evidence of leukemia at the time of the postmortem examination. This patient demonstrates a problem in therapy with these drugs—the clinical course of the disease simulates the toxic signs induced by the treatment, so that it is difficult to interpret the response.

Both antifolic acid preparations and steroid hormones have been shown to alter the course of acute leukemia when administered independently. Just what, then, is the proper way to use these drugs in the treatment of acute leukemia? Would it be better to try first one drug and reserve the other for a failure of response, as advocated by Pillers, *et al.*?[4] Or would it be better to combine the two drugs and treat the patient immediately when the diagnosis is made? Obviously, we are unprepared to answer this question now. It seems quite definite that the unknown mechanisms of action of these drugs in acute leukemia differ from each other. In our experience there seemed to be no antagonism between these two agents. Our results indicate that combined use of Aminopterin and steroid hormone therapy is capable of inducing a good clinical and hematologic remission in approximately one-half of the patients.

Summary

1. Folic acid antagonists and steroid hormones are two agents which have been shown to influence the course of acute leukemia.

2. In a series of 12 patients, with acute leukemia, treated with Aminopterin, 7 improved for a brief period but only 1 patient sustained a complete clinical and hematologic remission for a period of four months.

3. A series of 17 patients were treated with a combination of folic acid antagonists and steroid hormones. Eight of this number obtained a good clinical and hematologic response, and 6 of this number survived for a period of six months or longer after therapy was initiated.

4. Toxic manifestations of these drugs are at times indistinguishable from the clinical signs of the disease. This sometimes makes an evaluation of the therapy very difficult.

5. The earliest laboratory evidence of a remission is an increase in the reticulocytes. An increase in the number of platelets in the peripheral blood smear is an early and consistent sign of a good hematologic response.

6. Combined folic acid antagonists and steroid hormones can prolong the lives of some patients with acute leukemia. They by no means provide a cure for the disease.

(G.E.M.) Marshfield Clinic.

REFERENCES

1. Farber, S.: Proceedings of the Second Conference on Folic Acid Antagonists in the Treatment of Leukemia, Blood 7:97 (Jan.) 1952 (Supplement).
2. Wilson, S. S.: Observations on the effect of various folic acid antagonists on acute leukemia, Blood 6:1002–1012 (Nov.) 1951.
3. Rosenthal, M. C., Saunders, R. H., Schwartz, L. I., Zannos, L., Perez, S. E., and Dameshek, W.: The use of adrenocorticotropic hormone and cortisone in the treatment of leukemia and leukosarcoma, Blood 6:804–823 (Sept.) 1951.
4. Pillers, E. M. K., Burchenal, J. H., Eliel, L. P., and Pearson, O. H.: Resistance to corticotropin, cortisone, and folic acid antagonists in leukemia, J.A.M.A. 148:987–994 (March 22) 1952.

Acute Urinary Retention in Pregnancy

By W. J. PETTERS, M. D., L. W. SCHRANK, M. D., R. E. SCHRANK, M. D. and W. A. WAGNER, M. D.

Waupun

ACUTE urinary retention in the first four months of pregnancy has been reported previously only three times. The case presented by us is similar to those of Burdan, Maurer and Lich[1] (1951), Crabtree[2] (1912), and that of Smellie[2] (1877). These writers believe the condition is produced by pressure of the growing retroflexed uterus against the urethra and pubic arch. Its cause is not fully explained though it is believed that, in addition to retroflexion, some degree of uterine prolapse must be present. Narrowing of the pubic arch, such as was found in our patient, may also be a factor. Why it does not occur more frequently is a mystery.

Case Report

A 37 year old white primipara was first seen as an outpatient in the clinic in December 1950. She had missed the previous month's menstrual period, and she believed she was pregnant. A Friedman test confirmed this. In January 1951 a complete physical examination was negative except for retroflexion of the uterus and moderate narrowing of the pubic arch. There was no history of urinary disease or difficulty and aside from hay fever she had had no previous illnesses.

Early in the fourth month of her pregnancy she complained of abdominal swelling and pain. She had noted urinary frequency for the previous 72 hours and her abdomen had become enlarged. An abdominal tumor the size of a seven months' pregnancy and marked suprapubic tenderness were noted on physical examination.

After she was admitted to the hospital and a satisfactory pelvic examination could be made, she was found to have a retroflexed uterus the size of a four months' pregnancy and a tremendously distended bladder. This was catheterized and drained slowly of 10,600 cc. of clear urine. Cystoscopic examination and retrograde pyelography showed no abnormality other than a dilated bladder. Residual urine remained fairly high during the rest of her pregnancy, but gradually reduced to 100 or 120 cc., and she required catheterization on only one other occasion. Cystoscopic examination 10 months after delivery showed no abnormality except for some thickening of the mucosa and a residual urine of 12 cc.

(W.J.P.) 200 East Main Street.

REFERENCES

1. Burdon, S. B., Maurer, J. E., and Lich, R., Jr.: Acute retention in pregnancy, J. Urol. 65:578–580 (April) 1951.
2. Quoted by Burdon, Maurer, Lich.[1]

MARQUETTE SCHEDULES TWO POSTGRADUATE PROGRAMS

A course on "Diseases of the Chest" will be offered March 4, 11, 18 and 25 at Marquette University's School of Medicine, opening the spring postgraduate education program in the medical school.

Dr. Mischa J. Lustok, assistant clinical professor of medicine at Marquette, is chairman of the course which will be presented jointly with the Wisconsin Chapter, American College of Chest Physicians.

Guest speakers will include Dr. Benjamin M. Gasul, department of pediatrics and cardiology at Cook County Hospital, Chicago, Ill.; Dr. R. Drew Miller, consultant in chest diseases at the Mayo Clinic, Rochester, Minn.; and Dr. Erich M. Uhlmann, director of the tumor clinic, Michael Reese Hospital, Chicago.

Other speakers will represent Marquette's medical school, the medical school of the University of Wisconsin, the American College of Chest Physicians, the American Academy of General Practice, and the Veteran's Administration Hospital, Wood, Wis.

The course schedule is as follows:

March 4 **Diagnostic Significance of Presenting Symptoms**
March 11 **Interpretation of X-Ray of the Chest**
March 18 **Cardiovascular Diseases**
March 25 **Pulmonary Diseases**

Members of the American Academy of General Practice will be allowed 16 credit hours for the postgraduate course. Registration should be made through the Director of Postgraduate Programs, Marquette University Medical School, Milwaukee, Wis.

A postgraduate course on "Arthritis and Allied Rheumatic Disorders" will be presented April 15, 22 and 29 by Marquette University School of Medicine. Dr. Mark Garry, assistant clinical professor of medicine at Marquette, will direct the course.

Lectures and case presentations will be held at the medical school and at the Veteran's Administration Hospital. Leading contributors in the fields of inflammatory and degenerative joint disorders will appear under the auspices of the Wisconsin Arthritis and Rheumatism Foundation.

Coxsackie Virus Infections in Northern Wisconsin*

By A. F. RASMUSSEN, Jr., M. D., Ph. D., FRANCES A. CLINE, M. D.
Los Angeles, California Rhinelander
and
ALF F. BORGE, M. D.
South Bend, Indiana

THE Coxsackie (C.) virus was first described in 1948 by Dalldorf and Sickles who isolated that agent from two paralyzed boys in Coxsackie, New York.[6] Because of the apparent relation to poliomyelitis, much interest was shown in this new pathogen and intensive work has been undertaken in both the human and the experimental disease.[1, 9, 11, 15] Infection with this virus in infant mice is characterized by muscle necrosis with paralysis and death, which is used as a diagnostic test for the presence of the virus. There are two major groups of the virus: Group A causing only the muscle lesions and group B resulting in central nervous system and visceral lesions.[15] The physical characteristics (size and resistance to chemicals and heat) are quite similar to those of poliomyelitis virus.[2] Several other animals besides man and mouse are susceptible to this virus including chimpanzees, some species of monkeys, hamsters, and cotton rats.

The human illnesses from which C. virus has been isolated are of various types.[3] Group A has been isolated from outbreaks of herpangina, an ulcerative pharyngitis with fever, first described by Zahorsky,[21] which seems to be a specific clinical entity.[10, 17] Group B virus has been found in several cases of epidemic pleurodynia or Bornholm's disease in both the U. S. and Europe.[7, 8] In addition, all types of the virus have been found in paralytic and nonparalytic poliomyelitis, "summer grippe," "three-day fever," and apparently well people.[2, 3, 5, 14, 20] That the virus actually causes illnesses is well established by the correlation of symptoms with the presence of virus in patients and also by the development of specific antibodies in increasing titers following illnesses.[2, 10, 14] Further, laboratory infections have been reported,[19] as well as one case of intentional production of the disease in man.[7]

Since the Coxsackie virus has been found in almost every state and country where it has been sought, it would be anticipated that infections with C. virus would occur in Wisconsin. It is the purpose of this paper to describe the isolation of Coxsackie virus under circumstances which suggest that this virus may be an important cause of disease in our state.

In the summer of 1949 a study was begun in northern Wisconsin on the epidemiology of poliomyelitis with special reference to its relation to nonspecific illnesses which come and go in communities during the summer.* The village of Woodruff, Wisconsin, was chosen as a small community in which to obtain detailed data and laboratory specimens for possible virus isolations. The wholehearted support of the local physician, Dr. K. P. Newcomb, was invaluable in making this study. Several children's summer camps in which she was camp physician were visited because of epidemics of sore throats, fever, and other varied symptoms. Clinical data, stool specimens, and throat washings were obtained from several such camps. These specimens were frozen and stored at –20 centigrade until laboratory tests were completed.

Following the reports of Coxsackie virus isolations, it was decided to test the specimens for that agent. During the summer of 1950 virus isolations were carried out in the laboratories of the Department of Microbiology, University of Wisconsin Medical School. Specimens collected from two summer camps near Woodruff and from the town of Woodruff during 1949 were tested, as well as a few collected in 1950 from poliomyelitis cases and contacts by Mr. E. T. Sorensen on a similar field study covering the northern counties of the state.

In Woodruff the data were obtained by door-to-door interviews concerning recent acute illnesses, sanitation, and contacts with other illnesses. Special attention was directed toward families with three or more children, and specimens were obtained from 14 such households. Two or three stool specimens, a week or more apart, were obtained from each child. Throat washings in sterile saline were obtained on the same day as the stool. In the camps a similar procedure was used in addition to recording clinical data on infirmary patients.

The stool specimens were suspended in water (1 part in 4) and centrifuged at 16,000 revolutions per minute for 30 minutes. Following addition of penicillin and streptomycin, they were relatively bacteria free and could be injected intracerebrally into 24 to 48 hour old mice without harm to the mice. If the C. virus were present, the mice developed lethargy and paralysis, and died in 3 to 5 days. All inoculated mice were observed for 10 days following inoculation. At least one entire litter of 6 to 10 mice was used for the testing of an individual specimen. The throat washings were not found to contain virus.

---

* From the Wisconsin State Board of Health and the University of Wisconsin Medical School.

* The study was initiated by Dr. A. R. Zintek, former director, Section of Preventable Diseases, Wisconsin State Board of Health.

Results

Camp A (77 girls, two 4 week camp periods): This camp was first visited shortly after it began its second camp period and was in the midst of an epidemic of sore throats with fever. No hemolytic streptococci were found in several throat cultures, and the illnesses failed to respond to antibiotics. Paired stool specimens and throat washings were obtained a week or more apart from most of the girls. Daily oral temperatures, taken under standard conditions from each camper, were used as a rough index of the incidence of illness. The results from analysis of the clinical data and results from laboratory tests for C. virus are shown in Table 1.

TABLE 1—*Summary of clinical observations and recovery of Coxsackie virus at Camp A. There were 77 campers (age 9 to 14) and 15 young adult counselors.*

SIGNS AND SYMPTOMS:	INCIDENCE No.	INCIDENCE %*
Sore, inflamed throats	73	94%
Elevated temperature: 99.0 F.	65	84
to or above : 99.6 F.	29	38
: 101.0 F.	12	16
Infirmary patients with sore throat	27	35
Cervical lymphadenopathy	34	44
Stiff back or neck	12	16
Headache	11	14
Gastrointestinal upset	6	8
RESULTS OF VIRUS ISOLATIONS:		
Total number of stool specimens tested	152	
Campers' (108 paired, 21 single)	133	
Counselors'	19	
Number of stools positive for C. virus	20	13%**
Number of individuals positive	14	15 *
Campers	13	
Counselors	1	
Positive individuals with paired stools	11	
Number of above having 2 positive stools	6	
Number of persons ill in infirmary or having 99.6 F. temperature	29	
Number of above with positive stools	10	
Number of persons not having been ill	63	
Number of above with positive stools	4	

*Per cent of total campers.
**Per cent of stools tested.

Of the total campers, over 90 per cent had some evidence of pharyngitis during the four week period. Twenty-nine girls (38 per cent) had temperatures of 99.6 F. or greater on one or more days. Thirty-five per cent of the camp was ill in the infirmary at one time or another with symptoms of sore throat and fever. Stools from 75 of the 77 campers were tested for C. virus with paired specimens from 54 of them. Nineteen of the stools were found positive for the virus, representing 13 individuals. Of the 11 positive individuals from whom duplicate specimens were obtained, over one-half had virus in both stools. In an attempt to correlate the presence of virus with illness, it was found that of the persons who had been ill, 10 of the 29, or 35 per cent, had the virus in their stools whereas only 6.4 per cent of the remaining "well" group were positive for the virus. This would seem to indicate a positive relation between the virus and illness.

A graphic summary of the illnesses of those campers having virus in their stools is shown in

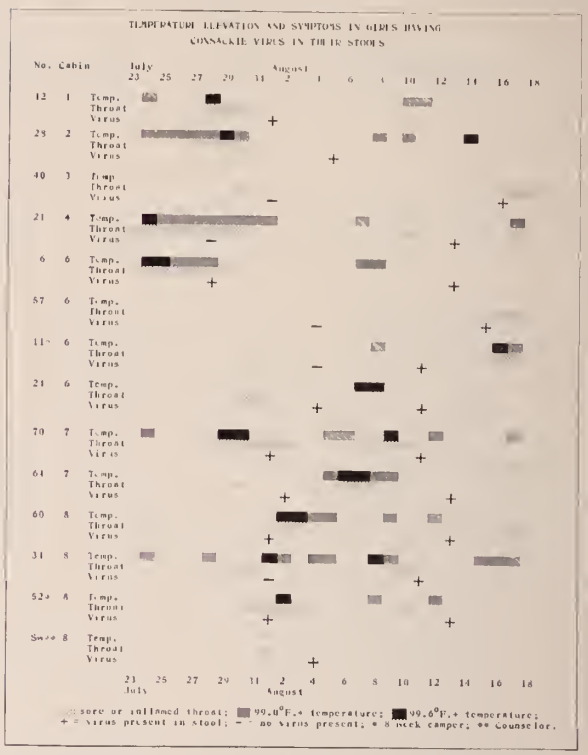


Fig. 1—Summary of observations in Camp A arranged to show the temporal relationsbips between the occurrence of illness and the recovery of Coxsackie virus.

figure 1, with special reference to the incidence of fever and sore throat. In no case was the virus found in the first but not the second of paired specimens, whereas the reverse was true in five instances. This suggests that the infection took place after arrival in camp and that the presence of virus was not merely due to a transient carrier state. It is realized that the clinical data presented are incomplete; notably lacking are more complete laboratory studies.

All of the viruses isolated from this camp were of Group A, Dalldorf type III, as determined by complement fixation and cross-protection tests.

Three groups of fecal specimens were tested for the presence of poliomyelitis virus by monkey inoculation. A pool from five individuals and paired specimens from a single individual produced characteristic symptoms and histologic evidence of poliomyelitis in two of the monkeys. Clinically, no poliomyelitis was diagnosed in the camp, although one girl was diagnosed as having nonparalytic poliomyelitis five days after leaving the camp. C. virus was found in each of the five individuals from the pool containing poliomyelitis virus.

Camp B (118 boys, two 4 week camp periods): This camp was visited in the last week of the second camp period following the report of paralytic poliomyelitis in one counselor and a camper. There was also an epidemic of sore throats with fever which appeared to be much more severe than in Camp A. The results of testing for Coxsackie virus

and the analysis of infirmary records are shown in Table 2.

TABLE 2—*Summary of clinical observations and recovery of Coxsackie virus, Camp B.*

	Incidence	
	No.	%
Total boys	118	100
Total infirmary patients	36	31
Total having had symptoms	68	58
Sore throats	45	38
99.6 F. temperature	30	25
101.0 F. temperature	23	20
Gastrointestinal upsets	17	14
Headaches	16	13
Paralytic poliomyelitis	2	-
Stools from patients positive for Coxsackie virus (9 tested)	4	

The data from this camp are not as complete as from Camp A, and thus not entirely comparable. However, on the basis of the histories and appearance of the patients, it was felt that the illnesses experienced at Camp B were more severe, with higher temperatures, more subjective complaints, and more swelling and erythema of the pharyngeal mucosa. Several cases of actual focal ulceration in the pharynx were observed and recorded, apparently similar to throats observed in herpangina. No poliomyelitis isolations were attempted, but on the basis of two paralytic poliomyelitis cases one might suspect a high incidence of that virus in such a closed group.

Woodruff (population 475, 121 households interviewed): Although there was no real outbreak of serious illness in this village, there was considerable sporadic respiratory illness present, mainly among the younger age group. One point of interest was the fact that adults had a higher incidence of illness when children were present in the household. Stools were tested for C. virus from eight individuals, representing six families. Positive results were obtained from only one family with three children. The youngest of these, a girl age 5, developed clinical symptoms indistinguishable from nonparalytic poliomyelitis, including fever, nausea and vomiting, stiff neck and back, and muscle spasm. The spinal fluid was normal except for a strongly positive Pandy test. The results of the tests are shown in Table 3. It is of interest to note that K. S. had no virus in the stool prior to the onset of symptoms, with the virus appearing after the onset of illness. T. S., on the other hand, manifested no evidence of illness despite virus in the stool.

TABLE 3—*Temporal relation of illness and recovery of Coxsackie virus in a family, Woodruff, Wis.*

	Age	Date				
		8-11	8-19	8-25	9-2	9-9
K. S.	5	—*	—	—	+ SSSSSSSS**	
V. S.	12	—				—
J. S.	16	+	—			

*+Stool positive for C.virus; — stool negative for C. virus.
**SS symptoms of nonparalytic poliomyelitis.

In specimens collected during the summer of 1950 from cases of paralytic poliomyelitis and their contacts, only one out of 19 stools tested showed definite presence of Coxsackie virus.

Discussion

The isolation of Coxsackie virus in Wisconsin is not surprising since it has been reported from several other states in all areas of this country, as well as several foreign countries.[2] This virus has also been recovered from patients with the symptoms of nonparalytic poliomyelitis in southern Wisconsin.[18] What importance is this finding to physicians in Wisconsin? For the family physician it may be of interest in explaining some of the previously undiagnosed, indefinite illnesses occurring during the summer and fall. Herpangina has been reported intermittently since Zahorsky's initial description in 1920, and it is apparently not uncommon. Although positive proof in the form of serial antibody studies is lacking, the illnesses described and the agent isolated agree with the results of studies of other outbreaks of herpangina. Pleurodynia frequently is a more severe disease and may offer serious difficulty in differential diagnosis, especially during the poliomyelitis season. Although laboratory diagnosis is impractical in sporadic illnesses caused by the C. virus, cognizance of this virus and the symptoms it produces may be helpful. In epidemics of illnesses due to the C. viruses, laboratory diagnosis is feasible and may be helpful to the community involved.

Concerning the actual relation of poliomyelitis to Coxsackie virus, two views are held. One is that there may be a significant relation because of frequently observed dual infections. No clear-cut influence on the severity or course of poliomyelitis in humans by the C. virus has been demonstrated. Dalldorf[4] has postulated an interference phenomenon and has shown a sparing effect by the C. virus in poliomyelitis in mice. Melnick's report[14] on a poliomyelitis epidemic suggests the reverse, that coincident Coxsackie infection may affect the course of poliomyelitis adversely.

Cole and others,[2] on the other hand, believe that previous frequent isolations of both viruses from poliomyelitis patients was due to faulty sampling and that actually the incidence of C. virus in such patients was not more frequent than could be ascribed to chance occurrence. They, therefore, dismiss the C. virus as being a significant factor in the epidemiology or pathogenesis of poliomyelitis. These variations of observations and opinion may in part be due to annual fluctuations in distribution and incidence of the viruses.

In our study it was shown that both poliomyelitis and C. viruses were present in the same individuals, as well as in the same outbreaks of illness. Since complete virus studies for poliomyelitis could not

LIBRARY OF THE
COLLEGE OF PHYSICIANS

be undertaken, little more can be stated. However, an apparent etiologic relation existed between the illnesses observed and the virus isolated in both the poliomyelitis-like and herpangina-like infections. It would appear that the relationship of the two viruses merits further investigation.

Several other interesting facts concerning Coxsackie virus have been reported which are worth mentioning. Within the two major groups of the virus there are several antigenic types which are capable of producing infection despite immunity to the other types.[11, 15] In mice it has been shown that immunity can be conferred upon infants through the colostrum and milk of immune mothers.[12] Using this knowledge, cross-protection tests have been devised to differentiate antigenically different types, which were used in this study. Another recent observation is the finding of extensive pancreatic necrosis in adult mice inoculated with group B virus.[16] A search for C. virus in human patients with acute pancreatitis would be of interest.

Summary

A study of illnesses in a village and two summer camps in northern Wisconsin is described. Group A Coxsackie virus was found in illnesses similar to herpangina, and an apparent correlation was found to exist between the symptoms of sore throat and fever and the presence of C. virus. This virus was also found in conjunction with paralytic poliomyelitis and poliomyelitis virus. Although the Coxsackie virus is not known to produce fatal illness, it is of interest to practicing physicians for the illnesses it may produce and its possible relation to poliomyelitis.

(A.F.R.) University of California Medical School.

REFERENCES

1. Beeman, E. A., Huebner, R. J., and Cole, R. M.: Studies of Coxsackie viruses: Laboratory aspects of group A viruses, Am. J. Hygiene 55:83–107 (Jan.) 1952.
2. Cole, R. M., Bell, J. A., Beeman, E. A., and Huebner, R. J.: Studies of Coxsackie viruses: Observations on epidemiological aspects of Group A virus, Am. J. Pub. Health 41:1342–1358 (Nov.) 1951.
3. Curnen, E. C.: Human disease associated with Coxsackie viruses, Bull. New York Acad. Med. 26:335–342 (May) 1950.
4. Dalldorf, G.: The sparing effect of Coxsackie virus infection on experimental poliomyelitis, J. Exper. Med. 94.65–72 (July) 1951.
5. Dalldorf, G., and Gifford, R.: Clinical and epidemiologic observations of Coxsackie virus infections, New England J. Med. 244:868–873 (June 7) 1951.
6. Dalldorf, G., and Sickles, G. M.: Unidentified, filtrable agent isolated from feces of children with paralysis, Science 108:61 (July 16) 1948.
7. Findlay, G. M., and Howard, E. M.: Coxsackie viruses and Bornholm disease, Brit. M. J. 1:1233–1236 (May 27) 1950.
8. Finn, J. J., Jr., Weller, T. H., and Morgan, H. R.: Epidemic pleurodynia: Clinical and etiologic studies based on one hundred and fourteen cases, Arch. Int. Med. 83:305–321 (March) 1949.
9. Howitt, B. F.: Isolation and differentiation of the Coxsackie group of viruses, Federation Proc. 9:574–580 (Sept.) 1950.
10. Huebner, R. J. *et al:* Herpangina, etiological studies of specific infectious disease, J.A.M.A. 145:628–633 (March 3) 1951.
11. Melnick, J. L.: Symposium on viral and rickettsial diseases; poliomyelitis, encephalomyocarditis, and Coxsackie groups of viruses, Bact. Rev. 14: 233–244 (Sept.) 1950.
12. Melnick, J. L., Clarke, N. A., and Kraft, L. M.: Immunological reactions of the Coxsackie viruses, cross-protection tests in infant mice born of vaccinated mothers. Transfer of immunity through milk, J. Exper. Med. 92:499–505 (Nov.) 1950.
13. Melnick, J. L., and Godman, G. C.: Pathogenesis of Coxsackie virus infection, J. Exper. Med. 93:247–266 (March) 1951.
14. Melnick, J. L., Kaplan, A. S., Zabin, E., Contreras, G., and Larkum, N. W.: An epidemic of paralytic poliomyelitis characterized by dual infections with poliomyelitis and Coxsackie viruses, J. Exper. Med. 94:471–492 (Dec.) 1951.
15. Melnick, J. L., and Kraft, L. M.: Differentiation of immunological types among the Coxsackie viruses, Federation Proc. 9:581–591 (Sept.) 1950.
16. Pappenheimer, A. M., Kunz, L. J., and Richardson, S.: Passage of Coxsackie virus (Connecticut-5 strain) in adult mice with production of pancreatic disease, J. Exper. Med. 94:45–64 (July) 1951.
17. Parrott, R. H. *et al:* Herpangina; clinical studies of a specific infectious disease, New England J. Med. 245:275–280 (Aug. 23) 1951.
18. Rasmussen, A. F., Jr., *et al.* Unpublished data.
19. Shaw, E. W., Melnick, J. L., and Curnen, E C.: Infection of laboratory workers with Coxsackie virus, Ann. Int. Med. 33:32–40 (July) 1950.
20. Webb, C. H., and Wolfe, S. G.: "Three-day fever"; an acute febrile disease of childhood (Further observations), Am. J. Dis. Child. 80:245–253 (Aug.) 1950.
21. Zahorsky, J.: Herpetic sore throat, South. M. J. 13:871, 1920.

BOOKLET ON "HEART DISEASE IN CHILDREN" NOW AVAILABLE

The American Heart Association and its affiliated heart associations throughout the country have begun distribution of a new booklet, "Heart Disease in Children."

The booklet is intended for parents, teachers, and all others concerned with the problems of child health and child care. It is recommended to physicians to use with parents of patients.

This booklet presents an up-to-date summary of the information now available on the prevention and treatment of rheumatic fever, the treatment of rheumatic heart disease, and the correction of congenital heart defects.

The booklet may be obtained from the Wisconsin Heart Association, 642 North 5th Street, Milwaukee 1, Wisconsin.

Practical Methods For the Diagnosis and Treatment of Emotional Illness*

By ANNETTE C. WASHBURNE, M. D.
Madison

EVER since the term psychosomatic became an accepted part of medical nomenclature, clinicians have been increasingly aware of the difficulties involved in (1) differentiating organic from non-organic disorders, (2) evaluating the relative amounts of somatic and psychologic pathology present in a given case, and (3) structuring effective therapeutic technics to meet the basic needs of the patient.

Our present day awareness of the close interrelationship between psyche and soma has served to highlight these difficulties. For example, a strict delineation of organic from non-organic disorders is now regarded with just skepticism; and, indeed, it is hard to conceive of a syndrome, which given sufficient time, will not contain elements of both. On the other hand, a relative evaluation of the approximate amounts of somatic and psychologic pathology present in each patient, although difficult, is possible and moreover is of practical importance.

In the first place, such an evaluation enables the clinician to study each patient from a binocular rather than from a monocular point of view.

Second, it precludes concentration on any one sign or symptom to the exclusion of other possibilities.

Third, it calls attention to the fact that a composite organism is reacting to a stress situation with both psychologic and physiologic mechanisms.

The initial stress may have been a disease process, a fractured leg, or an emotional conflict. Recognition of the type of stress is of obvious therapeutic necessity. However, it is equally necessary to consider the mechanisms adopted by the patient in his efforts to meet or counteract the stress, which in some fashion appears to threaten his life or welfare. The mechanisms employed are essentially those of defense; they may be used consciously or unconsciously.

To take an example—Richard K. has ulcerative colitis. His episodes of bloody diarrhea, cramps, and abdominal distention invariably follow exposure to a certain type of emotional conflict. However, these somatic responses constitute only a part of his overall reaction; in addition, he exhibits an acute depression, self depreciatory ideas, and social withdrawal. For the patient these psychologic symptoms are as distressing as the intestinal discomfort. If therapy is to be even moderately helpful, the underlying nature of these symptoms and the reasons for their selection must be ascertained. Why, for instance, does this patient, when confronted by a certain type of conflict stress, seek subconscious refuge in psychologic flight, as symbolized by his depression and withdrawal? Why does he not, as some others do, react with overt aggression and hostility? The answers to such questions are necessary if the patient is to develop insight and if improvement is to occur in his total illness.

Confronted with an ever increasing number of similar problems, some physicians have added a psychiatrist to their clinic staff, while others have undertaken postgraduate courses in psychosomatic medicine or have become readers of psychiatric texts and journals.

Unfortunately, for others a lack of time or interest or a failure to look beneath surface complaints has resulted in what might be termed a "none" or "all" attitude.

Thus certain physicians faced with the complexities of human behavior in general, and the annoying demands of neurotic patients in particular, have reacted by "shying away" whenever psychiatric symptoms present themselves. For many of this group our present inability to measure emotional maladjustments, conflict stress, or disturbed thinking, in terms of familiar standardized methods, has been a source of annoyance. Nor, must it be admitted, has psychiatry itself always proved helpful. The psychiatric jargon with its egos and its ids, its unresolved oedipal complexes, psychodynamisms, and frustrated libidinous impulses has caused many physicians to skeptically reject "the whole subconscious mess." In the words of a medical confrere, "I want to treat patients with straight physical disease, for I neither understand nor do I have the time to deal with anything else."

As opposed to this "none" attitude, there are those of the "all" school of thought, physicians who have constructed their psychotherapeutic efforts along the lines of oversimplification. For this group, therapy consists of what is optimistically called the "common sense" approach, an approach which nimbly skips basic psychiatric concepts and objective evaluations of the patient and confines itself to a subjective, intuitive glimpse of the surface problems. Such a glimpse is apt to regard the problems as examples of life dramas rather than as studies in psychopathology, and consequently therapy is based on "hunches" and the undeniable good will of the clinician rather than upon established technics.

Since there are many patients whose emotional needs are easily met, this type of symptomatic, sympathetic, if perhaps synthetic, treatment may prove to be quite successful. The difficulties, and the dan-

* Presented before the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952. (The Theresa Lemberg Rogers Memorial Lecture.)

ger, begin when attempts are made to stretch the "common sense, good will" approach to cover the intricacies of the compulsive-obsessive neurosis, the deep-seated hysteria, the paranoid personality, or the schizophrenic reaction.

At this point we may well ask ourselves if no middle road exists? In other words, are there no practical methods, concrete suggestions, or fundamental theories, which, on the one hand would challenge the "shy aways" to leave their ivory towers and, on the other, place a restraining anchor on the enthusiasm of the "treat alls."

Many psychiatrists allergic to such phrases as "practical methods," "concrete suggestions," and "fundamental theories" would be emphatic in denying that there is a middle road approach capable of use by the interested clinician. They would call attention to the fact that psychiatry is a complicated branch of medicine, not easily understood or rapidly learned, and that consequently attempts at simplification can only result in a dangerous superficiality.

These are valid statements and give pause for thought, but they should not constitute an insurmountable barrier for action; if they do, the walls which already separate one specialty from another will continue to grow higher and higher, and the various specialists will continue to see less and less of the whole patient.

The fact that psychiatry is a complicated branch of medicine should not serve as a total no trespassing sign to non-psychiatrists, for there are also other complicated branches of medicine, which, to some degree, should be rendered available to the psychiatrist. This does not assume that the non-specialist becomes an authority in another field, but it does assume that certain major tenets in each field are clarified to a point of usefulness. Thus the psychiatrist need not be certified in surgery, but he should be capable of suturing a simple wound; and the surgeon, although not certified in psychiatry, should be capable of treating the immediate psychologic needs of his patients with a simple but sound form of psychotherapy.

Within the framework of this reference, two major questions present themselves: (1) How can the average clinician know the type of psychiatric disturbance with which he is dealing? (2) How can the average clinician make more effective use of psychotherapy?

A very quick and apparently supercilious answer to the first question would be that he probably cannot. The explanation is to be found in the fact that few psychiatric syndromes are of the classical textbook type. On the contrary, there are numerous transitional stages, so that no fundamental clear cut separation can be said to exist between a psychosis and a neurosis, or indeed between many of the individual psychoses and neuroses. Long ago Freud called attention to the tendency of many psychiatric conditions to merge; more recently Adolph Meyer commented, "We should not say this is Schizophrenia or this is Manic Depressive Psychosis, but rather how much Schizophrenia and how much Manic Depressive Psychosis is present in the patient."

Of more practical use than attempting cut and dried rigid diagnoses is a quantitative evaluation of the strength of the personality structure of each patient. Such an evaluation is more practical because primarily we are dealing not with an example of an anxiety reaction, conversion hysteria, or paranoia but with a human being whose personality strengths and weaknesses have channelized into certain reaction patterns. Our ability to help the patient will therefore be based on our ability to assist him in increasing his personality strength and in decreasing its weakness.

While aware that we lack satisfactory methods for measuring personality strength according to any metric scale, the following criteria, carefully employed over a long enough period of time, may prove helpful. The relative strength of the personality structure may be evaluated through its ability to (1) deal with reality situations in an objective, logical, and realistic manner, to (2) control and successfully manipulate basic instinctive drives in conformity with the mores and socially acceptable ideas of the group, to (3) deal with its own rigidities, neurotic guilt, and tendencies for "over-control" in a flexible understanding fashion, and to (4) maintain its tolerance for repeated frustrations. These points can be put into practical application by means of a careful longitudinal history which bears in mind that the personality strength may have been constitutionally or environmentally weakened, particularly during the early formative years, and that physical illness, toxic agents, fatigue, and an accumulation of unfaced or unsolved conflicts can wear down the endurance strength of a previously adequate personality.

Consequently, the longitudinal history will be particularly concerned with the following:

1. Determining what types of reality situations the patient has been called on to meet and how he has met them. The following would be examples of reality areas from which conflict situations may arise; the home, sex, health, race, job, money, social acceptance, religion, war. These may be met either objectively or subjectively, logically or illogically, realistically or non-realistically. One or two examples will not suffice, rather a quantitative survey over the entire life history of the patient is indicated if we are to draw any conclusions as to the conflict areas usually involved and to the manner in which the patient usually meets or fails to meet them.

2. Conflicts in these areas reflect conflicts within the personality itself; specifically we must learn how the personality has sought to maintain an equitable balance between the demands of its instinctive drives, which if uncontrolled would lead to social condemnation, and the demands of its own censor control, which if blindly followed would lead to self condemnation.

3. In what manner has the patient handled the pressures of work and home and the tensions and frustrations peculiar to his method of living.

The careful longitudinal history can give us definite examples. A sufficient number of definite examples can serve as a rough but practical ordinal scale by which we may evaluate the personality strength of the individual.

If the personality structure gives evidence of chronic weakness or if it exhibits sporadic but frequent serious manifestations of weakness in meeting life situations, we may safely conclude that we are dealing with an example of serious illness which will require the services of a trained specialist. If, on the other hand, the personality structure gives evidence of basic strength to which it tends to return, despite temporary periods of weakness, then an opportunity for therapy by the clinician should be made available.

Question number two, "How can the average clinician make better use of psychotherapy?"

It should be stated in the beginning that psychotherapy (even in the hands of the best psychiatrist) will not benefit every patient. A brief consideration of some of the reasons for failure may serve as suggestions for improvement. In general the principal reasons for failure may be traced to either the patient or the therapist.

The Patient: Certain individuals are unwilling, unprepared or unable to accept or follow through with psychotherapy. Among the unwilling are those who have literally been dragged into the office by well meaning friends or relatives. Left to their own devices they would not have come.

Among the unprepared are those who, although they may have come willingly, can only indulge in tangential or peripheral conversation. They are eager to talk, up to a point, but not to the point. For them "the point" contains material which is emotionally traumatic and to which they have become psychologically sensitized. They may or may not be conscious of what "the point" actually is or what it signifies, but they have instinctively surrounded it with a halo of defense mechanisms. Attempts to break through the halo are met with evasions, resistance, hostility, or silence.

Among those who are unable to accept or follow through with therapy may be included that large, unfortunate, and ill defined group which, for want of a better term, has been referred to as the constitutionally inadequate. This vague and unattractive designation may be stretched to include the psychopath, the character neurosis, the infantile personality, and many drug addicts—sad examples of immature humanity propounding difficulties not alone for the physician but also for society.

In addition to these unwilling, unprepared, and unable to accept therapy patients, there are of course many others whose weak personality structure makes them poor therapeutic risks. Types referred to have been selected because they are among more common examples seen in everyday practice.

However, even with these types, particularly with the unwilling and unprepared patients, therapy could be more successful if the physician would keep in mind certain fundamental concepts:

1. It is essential to accept patients as they are and to structure treatment according to the particular needs of each one. This concept is in direct opposition to that of some therapists, who having learned one set procedure apply it to everyone. Such a poverty in technics may be compared to the surgeon who has mastered only one way of performing an appendectomy. If the appendix is not in its orthodox position, the operation may prove useless and conceivably cost the patient his life.
2. In accepting patients as they are, it is clear that the unwilling ones will not be helped by a strong directive or authoritative approach on the part of the physician. Instead the latter should make every effort to manifest a quiet sympathetic attitude towards whatever reasons the patient gives for his unwillingness. If somatic symptoms are present, many patients who are unwilling to discuss their psychologic problems will consent to a somatic history, physical examination, and a few laboratory studies. If the first several interviews are spent in this manner, a surprisingly large number of initially unwilling people will automatically extend their conversation until it covers their own emotional conflicts. This is most apt to occur if the original somatic history and physical and laboratory examinations have been undertaken with thoroughness and care and if, in addition, the physician has taken the time to explain in a simple way his reasons for each study or for any medication he may prescribe.
3. The unprepared group, who are good for only peripheral talking, are best left to talk themselves out. Eventually, as Doctor Lorenz is fond of saying, "they will run down." If, however, the therapist moves in too rapidly and attempts to push through their defense barrier (as exemplified in the verbal diarrhea), therapy will not only be unsuccessful but may prove highly dangerous. For example, some years ago a young and inexperienced psychiatrist, filled with a desire to help everyone as quickly as possible, became impatient when an obvious homosexual consumed the better part of four conferences in discussing his occupational work, his nausea, and his palpitations. Probing questions concerning sex, which had been foolishly interjected by the therapist, were either ignored or steam-rollered away in a rush of irrelevant words. Finally, the young psychiatrist could stand it no longer. "Why not be frank," he interrupted. "Quit beating around the

bush; your problem is that of homosexuality." The garrulous patient became instantly silent, rose, and without a word, walked out of the office. That night he put a bullet through his head. Had the therapist only realized that his patient had been "beating around the bush" because he was totally unprepared to face his homosexuality, had he accepted him as he was and permitted him to first talk himself out, there is a fair chance that a tragedy might have been averted. One reason for thinking so is because tangential talking, in addition to serving as an initially required defense, also provides the patient with additional time in which to "size up" the physician as a trustworthy person in whom he wishes to confide.

4. If there are any types of individuals who may be regarded as "therapy fast," they are to be found among the constitutionally inadequate. These emotionally immature people possess strong primitive drives with a vacillating and poor ability to control them. They exhibit extreme egoism. They have short interest spans, and their personalities may truly be considered as manifesting chronic weakness. These characteristics make them poor risks for long term therapy. Before agreeing to the treatment which these patients sporadically demand and as sporadically reject, the physician is well advised to weigh carefully his few chances of success and to consider whether the hours spent with these indigent personalities could not be used more effectively with other patients. It is true that many of these unfortunates can sometimes be "tided" over short critical exacerbations of personality weakness, and it would seem that therapy must be made available for this purpose. In other respects, however, their future frequently presents a community problem requiring, in addition to the services of the physician, those of the judge, the lawyer, the minister, the family, and the social worker. (Here reference is made only to the most disturbed and disturbing, in short to that group who perhaps more than any other harbor the perpetrators of the useless "sex murders.") Others with relatively minor disturbances can sometimes be carried along by short form therapy reserved for critical episodes and by the vigilant care of the responsible family.

After these comments on some of the difficulties encountered with patients, there remain only a few words concerning difficulties with the therapist. These difficulties, which may also lead to failure in therapy, may be the result of a lack of knowledge, training, and experience or they may stem from personality disturbances, which, although superficially surfaced, are easily aroused, especially by certain types of patients.

It is pertinent to recall that while physicians are expected to be observant of their patients, the patients (perhaps less expectedly) are definitely observant of their physicians. The nature of patient observations is often illuminating and frequently contains the clues as to why therapy failed. The following examples of actual remarks made by patients illustrate this point.

"Doctor won't say a word, he only grunts or repeats what I have just said."
"Doctor talks all the time, he never gives me a chance."
"Doctor is a cold fish."
"Doctor gets mad at me when I tell him I'm no better."
"Doctor doesn't understand me."
"Doctor never has any time."

And a few more personal ones.

"Doctor puts his feet on the desk."
"Doctor isn't physically clean."
"Doctor is too affectionate."

The physician who finds that his patients are consistently cancelling appointments or are seeking help elsewhere would do well to ask himself if the fault lies entirely with the patient.

In conclusion, it would appear that a middle road approach for the clinician who is interested in the psychologic as well as the somatic needs of his patients includes the following:

1. A general over-all study of the patient, thoroughly performed, and as rapidly carried out as the needs of the patient permit.

2. A concentrated effort, mainly through longitudinal histories, to evaluate the relative strength and weakness of the patient's personality structure.

3. An awareness of the need for a therapy which begins by accepting the patient as he is and terminates when between them therapist and patient have done all that they can to reduce personality weaknesses and to enlarge on personality strength.

1300 University Avenue.

EXAMINATION DATES SET BY INTERNATIONAL COLLEGE OF SURGEONS

Qualifying examinations for Fellowship in the U. S. Section of the International College of Surgeons will be held on the following dates in 1953: Feb. 2 and 3, May 4 and 5, Aug. 10 and 11, and Nov. 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine and the Cook County Hospital. Applicants are requested to address communications as follows: Harry A. Oberhelman, M. D., Secy., Qualification and Examination Council, 1516 Lake Shore Dr., Chicago 10, Ill.

A Study and Evaluation of 97 Selected Cases Seen at Otologic Clinics in the Wisconsin Hearing Conservation Program*

By MAXINE BENNETT, M. D.
Madison

THE Hearing Conservation Program in Wisconsin was started in 1947. Since that time a great deal has been learned and accomplished in audiometric screening and rechecking technics. An efficient program has evolved but many problems regarding satisfactory follow-up services of an educational and medical nature remain unsolved. To those interested in the program, these questions arise: 1. Are we actually conserving the hearing of these children? 2. How many of the recommendations made in the otologic clinics are carried out? 3. Is it possible to improve our follow-up procedures? 4. Is availability of medical service an important factor? 5. Has the condition responsible for the hearing impairment received adequate treatment when medical aid was sought?

With the above questions in mind the following study, primarily concerned with the medical follow-up, was made. Two Wisconsin communities were selected: the urban area of Racine where a very active hearing program has been combined with adequate public health nursing facilities and medical consultation; the other, the rural area of St. Croix County which also has had an active hearing program, but with limited public health nursing services and no otolaryngologist in the county. All of the cases selected for the study had been seen at previous otologic clinics. All otologic recheck examinations were made by the author.

In Racine, cases were selected at random, without knowledge of whether or not the earlier recommendations had been carried out. Children were chosen from four different schools in the city; two elementary schools, one junior high school, and one Catholic high school. Examinations were made at the individual schools and few parents were present. History and identifying information were obtained by the nurse, and the audiometric tests and ear, nose, and throat examinations were done by the author. Copies of the previous clinic examinations were available for reference.

In St. Croix County, the cases were carefully selected by the hearing consultant of the Bureau for Handicapped Children and by the public health nurse. An attempt was made to choose 25 children who had received treatment based on the previous recommendations, and 25 who had not received the treatment recommended at the earlier clinic. The examinations were made in four areas of the county, Hudson, New Richmond, Glenwood City, and Baldwin. The children were brought to the clinic and in most cases were accompanied by their parents. The history was taken by the county supervisors of special education and the county public health nurse, and the audiometric test was made by the county speech correctionist immediately before the ear, nose, and throat examination which was done by the author. As at Racine, the previous records were available for reference.

The reasons given for not obtaining treatment were interesting, informative, and included the following: "The distance to Wisconsin General Hospital was too great." "We did not know how to go about it, or where to go." "We have so many other problems, we haven't gotten around to it." "The oldest child had a tonsillectomy and adenoidectomy and had so much trouble, we didn't think it was worthwhile." "We are planning to have it done later." "Willie's tonsils never bother." "We didn't think it was necessary." "There was no rush, so we just didn't get to it." "Our family doctor thought tonsillectomy and adenoidectomy was not needed." "We decided to wait to see if hearing would improve without it." "Father had his tonsils out, and now he can't swallow." "No reason."

The following is a summary of observations based on the clinics held in Racine:

The number of patients rechecked was 52, of these 22 (42 per cent) had a conductive type deafness, 13 (25 per cent) had a nerve type deafness, 2 (4 per cent) had a mixed type hearing loss, and 15 (29 per cent) had essentially normal hearing.

Examination of the ears, nose, and throat of the 22 with a conductive type deafness showed the following conditions: 4 hypertrophied septic tonsils and adenoids, 10 secondary adenoids, 3 adhesive otitis media, 2 chronic suppurative otitis media, 1 postoperative radical mastoidectomy, 1 otosclerosis, and 1 a deviated nasal septum.

In the 2 cases of mixed type hearing loss, one had secondary adenoids and one had a secretory otitis media.

The 15 children who had normal hearing at recheck examination included 8 who had essentially normal ears, nose, and throat. Seven of the 15 had lymphoid hyperplasia in the nasopharynx, which at the time of examination did not affect the hearing.

* Originally presented to the Committee on Hearing Defects of the State Medical Society of Wisconsin.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

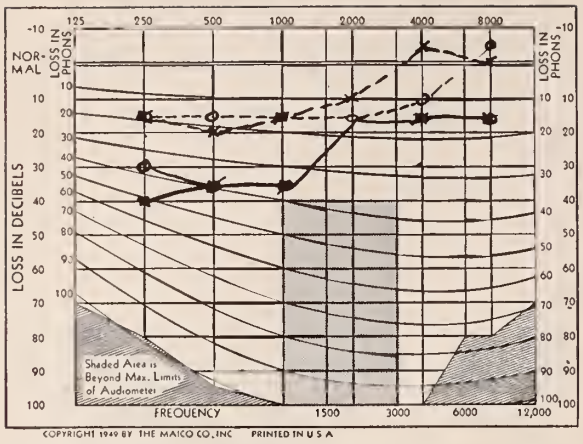


Fig. 1—J. H., age 8 years. Example of the improved hearing which followed an adequate tonsillectomy and adenoidectomy (June 1951). o Right Ear, x Left Ear, ———— 4/51, - - - - - - - - 1/52.

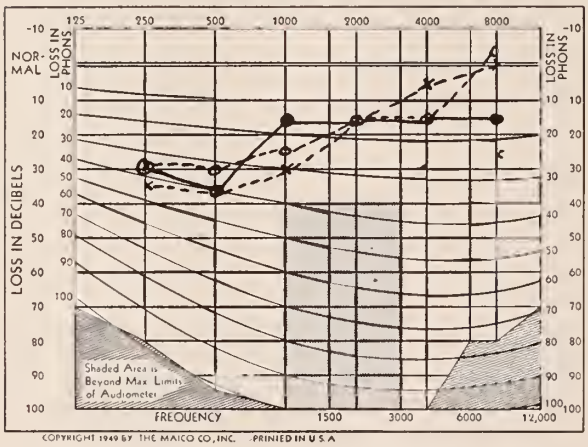


Fig. 3—S. A., age 7 years. Hearing impairment has remained the same. This child had not had tonsillectomy and adenoidectomy which was recommended in 1950. o Right Ear, x Left Ear, ———— 3/50, - - - - - - 1/52.

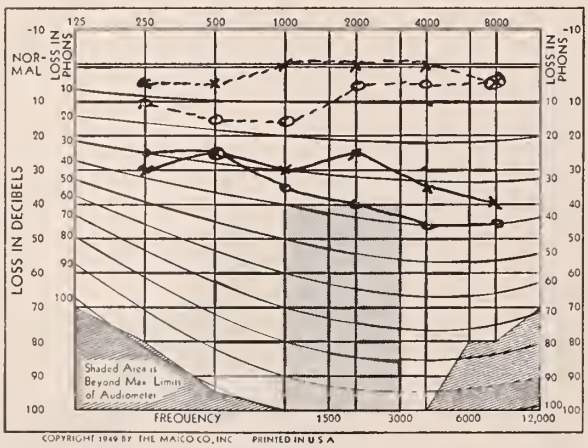


Fig. 5—R. L., age 11 years. An example of the improved hearing which followed surgical removal of secondary adenoids (June 1951). o Right Ear, x Left Ear, ———— 2/51, - - - - - - - - 12/51.

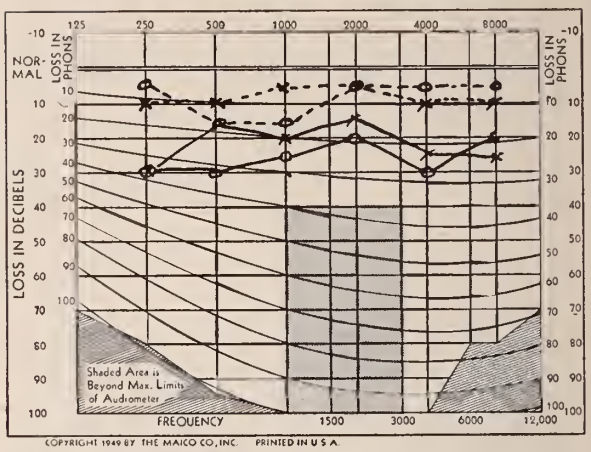


Fig. 2—A. E. P., age 9 years. Improved hearing which followed a tonsillectomy and adenoidectomy (May 1951). Child had had previous ear infections; tympanic membranes appeared scarred and thickened. o Right Ear, x Left Ear, ———— 5/51, - - - - - - - - 1/52.

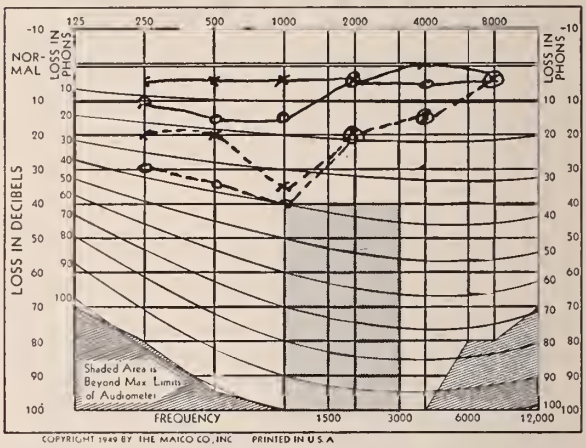


Fig. 4—D. M. K., age 11 years. Hearing impairment associated with secondary adenoids. Tonsillectomy and adenoidectomy performed in 1948. Rechecks examination January 1952; nasopharynx filled with adenoids, nasal airway completely obstructed. o Right Ear, x Left Ear, ———— 11/48, - - - - - - - - 1/52.

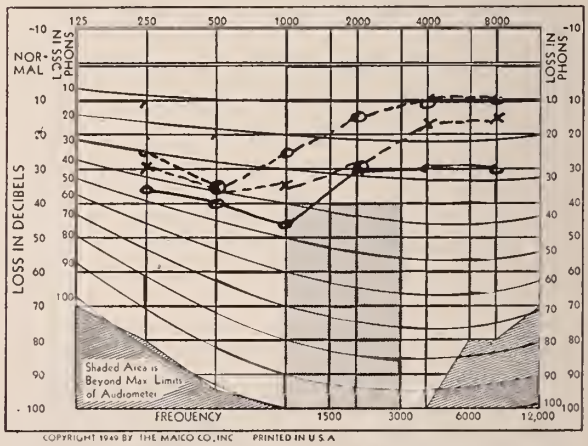


Fig. 6—P. M., age 16 years. An example of otosclerosis, first diagnosed at 14 years of age. Fenestration surgery performed on right ear, July 1951. At the time of the examination on December 1951, there was a moderate amount of purulent discharge in the right ear canal. o Right Ear, x Left Ear, ———— 12/50, - - - - - - - - 12/51.

In reviewing the recommendations made for these children at previous otologic clinics it was discovered that 44 per cent had carried out the recommendations. A tonsillectomy and adenoidectomy were recommended in 14 cases, but only five were done. Secondary adenoidectomy was recommended for 9 children and only one was done. Nine children were advised to have further medical treatment; 4 children consulted their physicians. A radical mastoidectomy was recommended for one and a fenestration operation was advised in a second case, both were performed.

A comparison of the hearing condition at the time of the recheck examination was made with the record of previous examinations. It was found that in 71 per cent of the cases in which the recommendations were followed, an improvement in hearing had occurred. In 66 per cent of those who did not follow the recommendations, the hearing was unchanged or worse.

The following is a summary of the observations in the otologic clinics held in St. Croix County:

The number of patients rechecked was 45, of these 26 (57 per cent) had a conductive type deafness, 8 (18 per cent) had a nerve type deafness, and 11 (25 per cent) had essentially normal hearing.

In the 26 children with conductive type deafness, the following abnormalities of the ears, nose, and throat were found: 7 had hypertrophied septic tonsils and adenoids; 5 had secondary adenoids with no local ear abnormalities; 2 had secretory otitis media; 4 had chronic suppurative otitis media; 2 had adhesive otitis media; 1 had acute otitis media; 1 had an abnormality in the middle ear (possibly a hemangioma); 1 had had a radical mastoidectomy; 1 had a suspected early otosclerosis; and 2 had nasal conditions producing obstruction.

In the 11 cases with normal hearing, 3 cases had no abnormalities in the ears, nose, and throat; 5 cases had hypertrophied tonsils and adenoids; 1 case had secondary adenoids; and 2 cases had adhesive otitis media.

In reviewing the recommendations made on these children at previous otologic clinics, 43 per cent had carried out the recommendations. Thirty-five recommendations for tonsillectomy and adenoidectomy were made, and 15 were carried out. Eleven recommendations were made for eustachian tube inflation, and only 3 had sought further care. Recommendations were made for 7 children to have more complete studies and evaluation, and of these only 2 had seen a physician.

Twenty of the 45 children received the care or procedure recommended at previous otologic clinics. Of these 20, 10 showed an improvement in their hearing. Of 10 who showed no improvement, 7 children still had ear, nose, and throat conditions which if corrected should improve their hearing, 3 had irreversible hearing losses and no improvement could be expected from any type of treatment.

Conclusions

1. The number of recommendations carried out were almost the same in both areas, Racine 44 per cent and St. Croix County 43 per cent.
2. Secondary adenoidectomy and eustachian tube inflations are the recommendations most frequently neglected or ignored. The value of the recommendation of eustachian tube inflation is to be questioned in a program concerned with hearing problems in children. The primary cause of the tubal obstruction should be considered first.
3. The importance of a well done initial adenoidectomy and tonsillectomy cannot be overemphasized.
4. The discovery of the case of otosclerosis was unexpected, but such cases may be common, and may be an argument for including older high school children in a hearing conservation program.
5. The function of hearing is variable. The majority of audiometric tests are given in the winter months when upper respiratory infections are prevalent, and this may account for those cases which showed a hearing loss at the time of the original otologic examination and normal hearing at the second examination. The reverse situation may also exist.
6. Improvement in hearing cannot always be credited to the patient's having received the recommended treatment. However, when obvious abnormalities exist in the ears, nose, or throat and a hearing loss is present, every effort should be made to try and correct it. There is everything to gain and very little to lose!
7. In those cases with chronic suppurative otitis media the hearing loss is of secondary importance. The existing infection with the danger of intracranial extension is of primary importance, when it is recalled that approximately 80 per cent of brain abscesses are of otologic origin.
8. Public health nurses are doing a good job in obtaining "follow-up."
9. A good many failures to carry out the recommendations are due to the fact that parents have not been convinced of the benefits to be gained.

Capitol Building.

DATE SET FOR MEETING OF AMERICAN GOITER ASSOCIATION

The next meeting of the American Goiter Association will be held at the Drake Hotel, Chicago, Illinois, on May 7, 8, and 9, 1953. The program for the three day meeting will consist of papers and discussions dealing with goiter and other diseases of the thyroid gland. Further information may be obtained by addressing Dr. G. C. Shivers, Colorado Springs, Colorado.

Changing Trends in the Treatment of Tuberculosis

As It Looks to Your State Board of Health

WHILE this title may not be true literally, it is not entirely amiss to say that the content of this article may be partially out of date by the time it appears in print, so rapid and profound have been the recent changes in the therapy of tuberculosis.

The original impetus for change was initiated by the advent of the first truly effective and relatively non-toxic anti-tuberculous drug, streptomycin, clinical investigation of which began in early 1946. Because of the chronicity of the disease and because of its unpredictable course in many cases, true evaluation of this antimicrobial agent was not accomplished in one year, nor in four. Indeed, our knowledge of the use of this drug, especially in combination with others, is still incomplete. However, the discovery of streptomycin accelerated a search for other chemotherapeutic agents, many of which were found to be either wanting in efficacy or too toxic for prolonged use. Thiosemicarbazone (Tibione), Viomycin, Neomycin, and Streptothricin, to name a few, fell into this category. From the search, however, there came one agent, para-aminosalicylic acid (PAS), worthy of note. When used alone, results from this drug were not too startling, but it offered the phthisiologist one real boon: the prevention of the development of strains of tubercle bacilli resistant to streptomycin. This resistance of organisms had appeared in patients treated for as little as 30 days when streptomycin had been used alone, and in a significant majority of patients serious degrees of resistance had developed within 120 days of treatment. However, the administration of PAS concomitantly with streptomycin prevented, with a marked degree of success, development of organisms resistant to either drug, and this factor in turn allowed longer periods of treatment with continuing improvement, while at the same time obviating much of the concern regarding drug resistance.

This addition to the medical armamentarium, which for the first time could in most instances halt the frequently inexorable progress of the disease and could in many instances actually reverse the disease process to a great extent, gave great impetus to the surgical aspects of treatment.

Although serious attempts at removal of tuberculous foci in the lung have been made for over the past 10 years, the operations were fraught with much risk and serious complications arose frequently. Consequently the existing surgical philosophy was slanted toward temporary collapse by pneumothorax, pneumoperitoneum, or phrenic crush, or toward permanent collapse by thoracoplasty or its modifications such as paraffin or lucite-ball plombage.

While the occasional complications of these procedures caused dissatisfaction among both the surgeon and the internist, the real dissatisfaction stemmed from the relapse rate in all these types of treatment. Thus arose the current surgical philosophy of extirpation of the lesion which, while usually controlled by collapse measures, remained within the patient as a potential source of later reactivation and spread.

Medical management with long term antimicrobial therapy has now enabled many a patient to come to surgery who once could have had no such good luck. Chemotherapy, by resolution of much of some diseased areas, has also made possible excision of smaller and smaller portions of pulmonary tissue; once where lobes and lungs were removed, now lobes, segments, and even smaller "wedges" are being taken, with preservation of more functioning lung tissue.

Because microscopic areas of infection may be missed at the operating table, postoperative chemotherapy and rest are usually routinely employed, but it may be said that after careful evaluation of resected cases the relapse rate is gratifyingly small.

Baffling questions still remain unanswered. The roles of isonicotinic acid hydrazide and its isopropyl derivative must yet be assessed. The first favorable publicity has fortunately died down, and it now appears that the drugs are about as effective as streptomycin alone and that perhaps their role will also be one of concomitant use with either streptomycin or PAS, or both.

The question of whether or not long-term chemotherapy (a year or two) will kill tubercle bacilli, or at least result in their natural death in a lesion, is a most intriguing and vital one. Some preliminary evidence would lead one to hope this may be the case, but much proof must be obtained before this dream of all phthisiologists can be said to have come true.

In spite of these encouraging trends, certain facts seem to stand out at present. The optimum place for treatment of tuberculosis is in a specialized center, the sanatorium. And, although the death rate from the disease continues to drop, the incidence of reported new cases remains about the same from year to year. It does not seem probable that we shall eradicate this disease in the immediate future nor that the tuberculosis sanatoriums of the country will be standing empty for at least the next few years.—ELLISON F. WHITE, M. D., *superintendent and medical director,* Wisconsin State Sanatorium.

THE MEDICAL FORUM

NEUPERT HEADS NATIONAL HEALTH OFFICERS' GROUP

Madison, Jan. 26.—Dr. Carl Neupert, head of the Wisconsin State Board of Health, was elected president of the Association of State and Territorial Health Officers at their annual meeting in December.

Dr. Neupert was formerly chairman of the association's Special Health Services committee, has served as a member of several of its other committees and was vice-president for the past year.

States, Territories Represented

The association is made up of the health officers of all the states and territories and the District of Columbia, with whom the Surgeon General is required by law to confer annually concerning regulations governing federal grants-in-aid projects and grants for public health purposes. Associated with them are directors of hospital survey and construction programs and mental health programs in those states in which they are not administered by the state health officer.

DR. C. N. NEUPERT

Cash Benefits to Veterans, Dependents Took 79 Cents of Each VA Dollar in '52

Washington, D. C., Jan. 23.—The cost of operating the Veterans Administration during fiscal year 1952 took less than 5 cents out of each tax dollar that VA spent in that year, VA announced today.

Cash benefits took slightly more than 79 cents, while medical benefits and veterans' counseling took nearly 14 cents. Construction and repairs took a little over 2 cents.

This information is contained in VA's annual report for fiscal 1952, now on sale at the Government Printing Office in Washington.

VA spent $5.99 billion during fiscal 1952. Of this amount, $4.86 billion was spent from funds appropriated by Congress and the balance from trust and other funds.

The amount spent from appropriated funds came from taxpayers while the amount spent from trust and other funds came from premiums paid by veterans on their GI life insurance, for which VA acts as trustee, and from additional sources other than taxpayers.

Of the $4.86 billion spent from the taxpayers' dollars, $3.85 billion was distributed in cash benefits to or in behalf of veterans or their dependents and beneficiaries under laws enacted by Congress. This represents 79.2 per cent of the expenditures from the taxpayers' dollars.

Billion for Care

The remaining billion was spent as follows: $664 million for medical, hospital and domiciliary care; legally authorized travel of veterans; veterans counseling and burial of veterans who died in VA installations; $224 million for administrative costs, including medical, hospital and domiciliary care and $113 million for construction of hospitals and other VA buildings and for major alterations and repairs to VA installations.

COURT SUSTAINS "NO CAUSE" PLEA IN PHARMACY CASE

The Wisconsin Pharmaceutical Association reports that it is appealing the decision of Judge Beilfuss to the State Supreme Court and hopes to have an opinion "within 60 days."

Madison, Feb. 2.—The Wisconsin Pharmaceutical Association failed in its court action to compel physicians to stop using their office employees as assistants in the dispensing of drugs to patients.

The association complaint sought a mandamus to require the State Board of Pharmacy to act against the physicians.

Circuit Judge Bruce F. Beilfuss, in an opinion dated December 31, 1952, sustained the position of the defendant board of pharmacy. The board, represented by Attorney General Vernon Thomson and Assistant Attorney General Warren Resh, demurred to the complaint on the basis that it was an attempt to determine the rights of physicians and their employees without their having an opportunity to be heard.

Charges Enforcement Failure

The suit was started in February in the Dane County Circuit Court and charged that the board of pharmacy failed to enforce the provisions of the "dangerous drug act" by not prosecuting physicians for several alleged violations of the act.

The pharmaceutical association asked for a judgment prohibiting "unqualified persons" employed in physicians' offices from "preparing, dispensing or delivering dangerous drugs."

An earlier opinion of the attorney general held that such persons may count out, package and deliver drugs to the physicians' patients providing these tasks are performed under the physicians' direction and supervision.

Judge Beilfuss upheld the contention of the board of pharmacy that the complaint failed to state a cause of action inasmuch as there was not a controversy that entitled the plaintiff to obtain a declaratory judgment.

(Continued on page 148)

MUCH LEGISLATION AFFECTING MD's CAN BE EXPECTED

Washington, D. C., Jan. 30.—Several pieces of legislation directly affecting the medical profession can be expected to appear for the consideration of Congress during the present session.

Of major interest are bills similar to the Reed–Keogh bills of the 82nd Congress which would authorize persons not covered by the employee-employer supported, tax-free pension plans to deduct from their income limited amounts for annual premiums toward annuities. Either $7,500 or 10 per cent of income could be set aside for the purchase of an annuity. However not more than $150,000 could be so accumulated tax free. Funds so set aside could not be withdrawn until retirement unless the insured suffered a serious physical disability.

Some sort of bill extending the present *doctor draft* will undoubtedly be introduced. According to the AMA Washington office, the AMA will certainly be requested to state its views on either writing a new law or extending the present one.

Would Amend Social Security

A bill which would amend social security laws to provide for a waiver of premium in cases of disability was introduced in the 82nd Congress. This was a new approach to break through the barrier of previous congressional objection to the addition of a new type of permanent and total disability benefit to the existing program. This provision already has been introduced again, and the AMA is assembling material, expecting to testify at the hearings, as it realizes the danger of permitting the federal government to enter the field of medical care via the social security program.

Several bills proposing hospitalization for aged beneficiaries of social security insurance were introduced in the 82nd congress and have appeared again in 1953.

Senator Bricker (Ohio) and 60 co-sponsors have drafted a resolution providing that no treaty or executive agreement shall be made respecting the rights of citizens of the United States; nor shall any international organization assume any of the legislative, judicial or executive powers of the U. S.

This was done out of recognition of the danger of a compulsory health and welfare program being foisted on this country by way of the International Labor Organization. The ILO could draft a "convention" calling for uniformity in the fields of labor, health and welfare of its member countries, and as our law now stands, ratification by two-thirds of the Senate could place such a treaty in effect. If this Bricker resolution is passed by the present Congress, it then must be submitted to the states for ratification.

A bill proposing the establishment of an *independent coordinating agency* to bring about a better integration of all federal medical activities and programs will be reintroduced in this Congress. This was drafted by Senator O'Conor (Maryland) after most of the organizations concerned balked at a proposition that would have thrown them into a consolidated department with cabinet status. The coordinating agency would have power only to advise and recomfend, but could bring about fuller utilization of existing facilities.

A variety of bills advocating federal financial assistance to local health units have appeared in the past and will probably be introduced again.

Provision of federal funds for emergency maternity and infant care for wives of service men will probably be brought up again with a host of new suggestions. The AMA Washington office points out that doctors in military service are now giving much time to taking care of soldiers' dependents, and therefore the need for EMIC does not exist.

Federal aid to medical and nursing education will doubtless be argued again during this session. The AMA contends that only if private and state support fail should schools look to the federal government for aid. Further, the association believes that federal assistance, if necessary, should be in the form of one-time construction grants for building and facilities.

New Veterans' Bills

The opening day of Congress likewise saw a flood of new veterans' benefit bills which were referred to the Veterans' Affairs Committee. These included hospital care and treatment for veterans residing abroad, presumption of service connection for malignant tumors within two years after separation from service, presumption of service connection for all types of tuberculosis, and so on.

A bill has likewise been introduced to credit service in the armed forces of co-belligerents in the doctor draft. This is to correct a situation under which alien physicians now living in the U. S. may be called up for service even if they have had long service previously.

PUBLIC RELATIONS TIP FOR FEBRUARY

Every county medical society should consider having the name of the society listed in the telephone directory. It can be listed either under the president's name or that of the secretary.

This listing can be placed in the directory of the town where the officer lives, or in all the principal towns in a county. It can be changed yearly, as the officers change.

Dr. Buie Asks Help in Revising Principles of Medical Ethics of AMA

Chicago, Jan. 18.—Dr. Louis A. Buie, Rochester, Minn., chairman of the AMA Council on Constitution and By-Laws, is asking the assistance of all state and county societies in the tough job he and his council face. They must study and evaluate the Principles of Medical Ethics of the AMA with a view to recommending changes that will clarify existing misunderstandings.

According to Dr. Buie, the most controversial sections of the Principles are Section 4 on advertising, Section 5 on publicity and Section 6 on patents, commissions, rebates and secret remedies. All of these sections are contained in Chapter 1.

Dr. Buie asks all physicians who have suggestions to make regarding the amendment of these or any other sections to write them out in complete detail and submit them to Dr. George F. Lull at AMA headquarters in Chicago.

COUNTY SOCIETY MEMBERS IN 71 TOWNS GIVE VOLUNTEER BLOODMOBILE SERVICE

Madison, Jan. 19.—Members of county medical societies in 71 communities are providing outstanding cooperation with the Badger Regional Blood Center program involving the bloodmobile.

Last spring, the center discontinued the practice of sending a doctor with the bloodmobile and requested the cooperation of county societies to provide the necessary medical coverage. Since then, volunteer medical supervision has been furnished by doctors in all the major towns and cities of the following counties:

Brown	Marinette
Columbia	Marquette
Crawford	Monroe
Dane	Outagamie
Dodge	Portage
Fond du Lac	Richland
Grant	Rock
Green	Sauk
Iowa	Shawano
Jackson	Sheboygan
Jefferson	Vernon
Juneau	Walworth
La Crosse	Waupaca
Manitowoc	Waushara
Marathon	Winnebago
	Wood

The Badger Regional Blood Center now furnishes blood and derivatives to 51 hospitals in southern and central Wisconsin. Residents of the following counties are eligible to receive blood free of charge wherever they are hospitalized.

Furnishes 51 Hospitals

Adams	Jackson
Brown	La Crosse
Columbia	Lafayette
Dane	Marquette
Dodge	Portage
Fond du Lac	Richland
Grant	Sauk
Iowa	Vernon
Jefferson	Walworth
Juneau	Waupaca

Residents of areas served by the Beloit, Sparta, Neenah and Menasha Red Cross chapters are also in the blood program.

Blood is collected in the following counties for defense purposes only:

Clark	Outagamie
Crawford	Rock
Green	Shawano
Lincoln	Sheboygan
Manitowoc	Taylor
Marathon	Waushara
Marinette	Winnebago
Oconto	Wood

The St. Paul Regional Blood Center supplies hospitals in the following 10 counties:

Barron	Pepin
Burnett	Pierce
Buffalo	Polk
Dunn	St. Croix
Eau Claire	Washburn

The Blood Center has expressed gratitude to the committee on blood banks of the State Medical Society for its excellent service in an advisory capacity. Chairman of this committee is Dr. W. D. Stovall, Madison. Other members are Drs. C. N. Neupert, Madison and T. J. Greenwalt, Milwaukee.

S. L. HORMAN

Horman Made Chairman of Chamber Committee

Madison, Jan. 10.—The appointment of S. L. Horman. Milwaukee, vice-president of the Time Insurance Co., as chairman of the State Chamber of Commerce's Committee on Social Security has been announced by William E. Rutz, Fond du Lac, president of the state chamber. Mr. Horman succeeds Carl N. Jacobs, president of the Hardware Mutuals of Stevens Point.

One of the earliest of committee activities will be sub-committee studies of bills expected to be presented in the 1943 session of the Wisconsin Legislature. These subcommittees deal with unemployment compensation, old age and survivors insurance, cash sickness and disability benefits and workmen's compensation.

Michigan Has Mobile Hearing Test Chamber

Lansing, Mich., Jan. 10.—Residents of Michigan who are deaf or hard of hearing will soon receive the benefit of a new mobile unit for hearing test purposes. This unit is a small house-trailer with a sound-proofed room in the back and a control room in front. It will be taken on an extended tour of Michigan, its service free of charge. The Michigan Association for Better Hearing is sponsoring the project.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

STATE OFFICIALS OUTLINE PLANS TO NEW COMMISSION

Madison, Jan. 15.—The wide range of activities of several state departments was outlined at the organization meeting of the Commission on State Departments of the State Medical Society on January 10.

Dr. T. W. Tormey, Jr., Madison, chairman, explained that the commission will advise state departments in problems of special concern to the medical profession and will study the trends and developments in state and federal government which have an impact on the public health.

Representatives of four major state departments appeared at the commission meeting.

Dr. E. H. Jorris, assistant state health officer, pointed out that the State Board of Health has an annual budget of approximately $1,750,000. It employs more than 100 persons in state institutions and about 300 in the department itself.

The board of health has about 40 divisions and sections. Some of these of most importance to practicing physicians are the sections on maternal and child welfare, industrial hygiene, preventable diseases, and local health units.

The board also directs the operation of 9 district offices throughout the state.

The Department of Public Instruction is of direct concern to the medical profession through the Bureau of Handicapped Children, of which Frank Powell is director. This bureau carries on extensive activities dealing with the deaf and hard of hearing, crippled children, school health, and rheumatic fever.

The department deals with 900,000 elementary and secondary school children in Wisconsin, 25,000 teachers, 6,000 school boards and 19,000 school board members.

Last year the bureau provided audiometric tests for 200,000 school children. Mr. Powell envisions a hearing test for every school child in Wisconsin every three years under the program now in operation. He pointed out that the department was also considering activities in the field of mental health.

For Local Government

Mr. Powell said: "We should be jealous of maintaining a strong, vigorous, and well-directed local government. We, in this department, dislike strong and big federal government just as much as we dislike the same things in state government."

Mr. Adrian Towne of the Rehabilitation Division of the Department of Vocational and Adult Education explained that this department spent about $600,000 in 1949–50 to assist disabled persons. The purpose of this program is to remove disabled individuals from relief rolls and to lessen the amount of their state support by reducing or improving their disability through medical care.

In general, the department uses the Veterans Administration fee schedule as a guide in payment of physicians for service rendered to such individuals. Only adult, employable persons are assisted by this program.

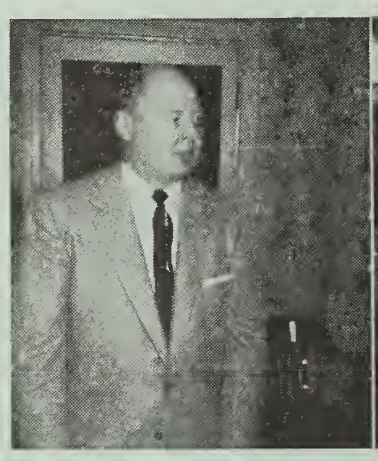
Problems of the Department of Public Welfare were outlined by John Tramburg, director of that department.

Medical problems of the correctional institutions are usually handled by full-time physicians although local physicians sometimes assist in various cases. There are many medical problems in connection with the child welfare activities of the department.

The Child Center at Sparta has 102 children who receive medical attention from Sparta physicians including emergency surgery. However, surgery of the "elective" type is normally done at Wisconsin General Hospital.

Mr. Tramburg pointed out that Wisconsin has more than 300,000 persons over 65, more than 50,000 of whom are drawing Old Age Assistance. This program is administered through the Division of Public Assistance and annually involves the expenditure of nearly $8,000,000 for total health care.

He pointed out that current legislative discussions were stressing the need for cutting the "health" expenditures for the aged in Wisconsin. New programs are about to be developed for the payment of health and medical care for these individuals and it is Mr. Tramburg's hope that systems can be



PHYSICIANS who are members of the Medical Society's new Commission on State Departments were snapped conferring with members of the state departments with which they will consult. Left, *Adrian E. Towne*, Supervisor of Medical Services of the Rehabilitation Division of the State Board of Vocational and Adult Education addresses the group. Center, left to right, *Frank V. Powell* of the Bureau for Handicapped Children talks with *Dr. H. A. Sincock*, Superior, chairman of the commission's Division on Crippled Children, and *Dr. T. L. Tolan*, Milwaukee, chairman of the Division on Visual and Hearing Defects. Left, *Dr. E. H. Jorris*, Assistant State Health Officer confers with *Dr. J. A. Schindler*, Monroe, chairman of the Division on Geriatrics.

DR. T. W. TORMEY, JR. presides; Dr. H. Kent Tenney at left.

devised which will win approval of the state and the physicians, and, at the some time, meet the patients' needs.

Mr. Tramburg said: "There is a great deal of emotion in discussion of this problem. There are many misstatements and a lot of misinformation. We need cool heads, facts, and the ability to substantiate them if we are going to develop the best possible program."

Mr. Tramburg emphasized the critical shortage of physicians for the care of the mentally ill in Wisconsin institutions. The department is now developing a training program in cooperation with the University of Wisconsin which, it is hoped, will supply an adequate physician complement for the mental institutions. The program involves a 5-year residency in psychiatry, with 3 years at the University of Wisconsin and the final two years in an institution. Seven persons are accepted in these residencies each year.

In summing up the discussion, Doctor Tormey pointed out that the individuals who appeared before the commission had expressed a philosophy completely different from that emanating from the federal level during recent years. He stressed the need for state and local direction as a means of maintaining the individual as of paramount importance in any state program.

"Under the direction being given by the men who appeared at this commission hearing today, health should be and is above politics," Doctor Tormey concluded.

MEMBERS NAMED TO COMMISSION

Madison, Jan. 11.—Members of the nine sub-divisions of the new Commission on State Departments were named at the organization meeting January 10.

Appointed to the division on tuberculosis and chest diseases were Drs. L. W. Moody, Bayfield; H. A. Anderson, Stevens Point; C. M. Yoran, Wausau and G. C. Owen, Milwaukee. Dr. J. D. Steele, Milwaukee, is chairman.

The division on maternal and child welfare will have as its members Drs. A. L. Hunter and T. V. Geppert, Madison; G. S. Kilkenny, Milwaukee; A. H. Stahmer, Wausau; J. D. Wilkinson, Oconomowoc; F. G. Johnson, Jr., Superior and D. D. Wilson, Fond du Lac. Dr. R. F. Purtell, Milwaukee, is head.

To the division on visual and hearing defects, of which Dr. T. L. Tolan, Milwaukee, is chairman, were named Drs. E. J. Zeiss, Appleton; W. M. Nesbit and J. W. Doolittle, Madison and A. B. Schwartz, Milwaukee.

Members of the division on rehabilitation will be Drs. P. J. Collopy, Milwaukee; E. P. Roemer, Madison; J. G. Beck, Sturgeon Bay and C. C. Gascoigne, Kohler. Dr. R. G. Piaskoski, Wood is chairman.

Dr. J. A. Schindler, Monroe, chairman of the division on geriatrics, will have as members of his division Drs. Owen Otto, Milwaukee; M. J. Musser, Jr., Madison, A. M. Hutter, Fond du Lac; M. T. Morrison, Mt. Horeb and R. H. Quade, Neenah.

Appointed to the division on school health were Drs. A. C. Edwards, Racine; F. J. Mellencamp, Milwaukee; A. H. Heidner, West Bend; G. M. Shinners, Green Bay and W. R. Manz, Eau Claire. Division chairman is Dr. E. H. Pawsat, Fond du Lac.

Members of the division on public assistance will be Drs. H. W. Carey, Lancaster, chairman; E. W. Schacht, Racine; W. K. Simmons, Rhinelander; C. M. Carney, Beloit; C. A. Olson, Baldwin and L. F. Morneau, Bear Creek.

Members of the division on crippled children will be Drs. J. W. Nellen, Green Bay; D. W. McCormick, Fond du Lac; R. C. Waisman and M. G. Peterman, Milwaukee; K. P. Newcomb, Woodruff and F. D. Bernard and A. B. Weinstein, Madison. Dr. H. A. Sincock, Superior, is chairman.

To the division on nervous and mental diseases were appointed Drs. C. F. Midelfort, La Crosse; K. M. Keane, Sheboygan, J. T. Petersik, Winnebago; Chester Wade, Milwaukee and W. J. Urben, H. H. Reese and H. K. Tenney, Madison. Dr. E. D. Schwade, Milwaukee, is chairman of this division.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

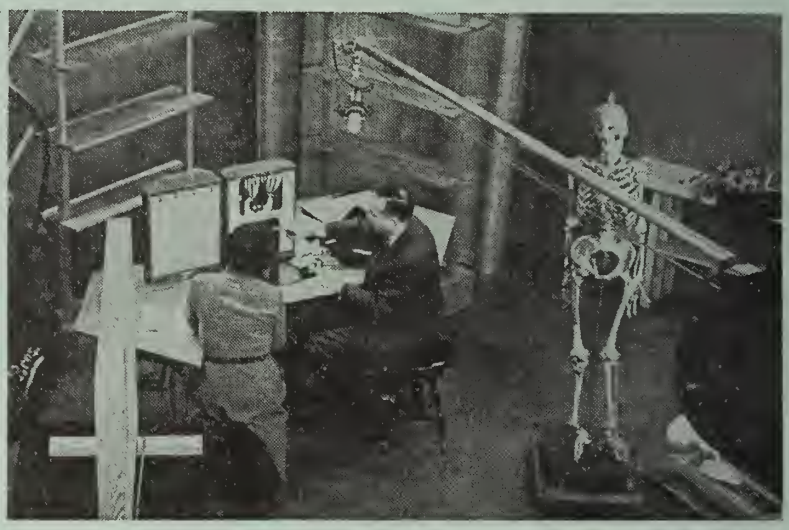
Milwaukee Society Is Cooperating in Health Series on Television

Milwaukee, Jan. 20.—The Medical Society of Milwaukee County is cooperating with WMTJ-TV in the presentation of a televised series of medical programs entitled "Your Family's Health."

This series which began November 11 and will conclude June 30, is the second of its kind to be attempted in Milwaukee and has to date been very well received. It appears most Thursday afternoons at 1:30.

The programs are of the demonstration type with Beulah Donohue interviewing a doctor in subjects relating to his own specialty.

The series began with two programs on the skeleton and two on the muscles. Three programs on the respiratory system are planned for January, three on the circulatory system for February and three on the nervous system for March. Other subjects to be treated will be the digestive system, the skin, safety devices, the senses of sight and hearing, allergy, cancer, epilepsy and psychosomatic medicine.



DR. FREDERICK GAENSLEN shows new ways of treating damaged bones not only to emcee Beulah Donohue but to a vast television audience. His appearance was the second in a series on "Your Family's Health" being presented over WTMJ-TV in cooperation with the medical society of Milwaukee county.

New Details of VA Survey Become Known

Washington, Jan. 10.—As more details of the survey resulting in the reorganization of the Veterans Administration come to light, two facts of major interest to physicians become known.

One of these is that the report raises a series of questions about non-service connected cases and recommends that Congress look into the problem.

The other is that Chief Medical Director Joel T. Boone and his staff are to carry far heavier responsibilities.

The report states that proper clarification or revision of the law dealing with non-service connected disabilities "will go far toward correcting a situation which has made the medical program of VA the constant target of criticism and misunderstanding, much of it undeserved."

It notes that it is apparent Congress intended VA to render care to non-service connected cases because it has authorized construction of more beds than needed for service-connected disabilities. "Yet the beds authorized are too few to take care of the potential non-service connected load," the report adds.

The new administrative set-up will place under Dr. Boone four assistant chief medical directors and a controller of equal rank who will handle all budgetary matters in the department and maintain contact with the overall controller of VA.

The newly defined departments, each of which will have its chief under Dr. Boone, will be planning, operations, research and education, and dentistry. The operations director will handle domiciliary homes, clinics and canteens as well as the 157 veterans' hospitals.

The survey report, a ten volume affair, is not yet for sale to the public.

Davis Gives Figures on Federal Employees

Washington, D. C., Jan. 30.—Congressman Glenn Davis writes from Washington, "Latest available figures on Uncle Sam's civilian employees show there are about 3,400,000 in the continental U. S. of which slightly under 22,000 are in the State of Wisconsin.

"Civilian employees of Uncle Sam abroad number almost 400,000 of which a little less than half are American citizens, and over 200,000 are foreign civilians. President Truman's budget message contemplated an increase during the next fiscal year of more than 100,000 federal employees."

22 Marinette MD's Contribute to SMS Student Loan Fund

Madison, January 20.—Twenty-two members of the Marinette County Medical Society have made contributions to the student loan fund of the State Medical Society. This number constitutes a high percentage of the society's membership.

These Doctors Gave

Marinette doctors from whom money has been received are:

J. M. Bell
C. H. Boren
Clark Boren
J. W. Boren, Jr.
G. R. Duer
T. W. Kirmse
C. E. Koepp
J. V. May
P. R. McCanna
K. J. Moss
A. T. Nadeau
K. G. Pinegar
R. J. Rogers
H. F. Schroeder
J. D. Zeratsky

Other county contributors are:

John Grindrod, Peshtigo
H. W. Haasl, Peshtigo
R. J. Maginn, Goodman
R. B. Pelkey, Pound
L. H. Graner, Coleman
R. T. Lamb, Niagra and
E. A. McCormack, Niagra.

Dr. Bell is president of the Marinette County Society.

TWENTY-SEVEN 4-H CLUBS GET SMS AWARDS FOR GOOD HEALTH PROGRAMS

Madison, Jan. 25.—Twenty-eight 4-H Club health award certificates are being presented this month by the Council on Medical Service of the State Medical Society.

Dr. R. L. MacCornack, Whitehall, council member who directs activities in the field of rural health, announced the awards.

The 4-H Health Awards are given to a maximum of four clubs in each county conducting the best health improvement programs, based on both individual and group achievements.

The winning clubs and their leaders are as follows:

Club	*Leader*	
Summit Valley	Mrs. Ernest Kraft	Oconomowoc
Brush Creek Knowledge Seekers	Mrs. Ed Henson	Richland Center
Browntown Busy Beavers	Mrs. Raymond Montgomery	Browntown
Liberty Pole Boosters	Mrs. Roy Robson	Viroqua
Sunrise 4-H Club	Mrs. Bernard Genskow	Marion
View Point	Mr. and Mrs. Vern Laverty	Mineral Point
Dodge Corners	Mrs. Ed Tonkin	Mineral Point
Green Grove 4-H Club	Mrs. Otto Pries	Whittlesay
Spring Creek	Mrs. Harvey Crotteau	Rice Lake
Mayflower	Mrs. George Miller	Antigo
Twin Pine	Mrs. Henry Tum	Fall Creek
Lucky Clover	Mrs. Ed Giebler	Elkhart Lake
Friendly	Mrs. Owen Melin	Withee
Sand Creek	Mrs. June Clift	Sand Creek
4-H of Cream	Elmer Bade	Alma
Peppy Pals	Mrs. Edwin Quam	Dane
Grant	Mrs. Clarence Timm	Wisconsin Rapids
Lucky Lincoln	Mrs. Frank Gowgh	Eagle River
Bungalow Badgers	Mrs. Ralph Erickson	Denmark
Ellington	Mr. and Mrs. Elmer Root	Hortonville
Maple Valley	Mr. and Mrs. Herb Buseman	Gillett
Wood Creek	Mrs. Elmo Peterson	Siren
Friendly 4-H	Jerry Lucas	Catawba
Mount Morris	Mrs. Rueben Anderson	Wild Rose
Happy-Go-Lucky	Martin Tomczak	Weyerhauser
Marquette Hilltoppers	Mrs. Lester Heindel	Marquette
Bunker Hill Buddies	Mrs. Earl Rewey	Platteville
Stitzer Go Getters	Mrs. Milton Smith	Stitzer

RESEARCH COUNCIL RELEASES FIGURES ON LONG ILLNESSES

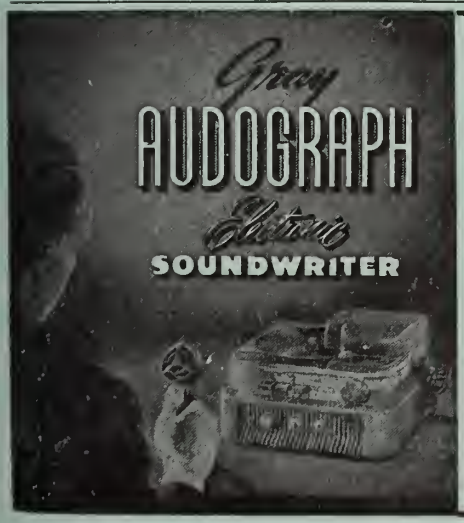
Chicago, Jan. 14.—The Research Council for Economic Security has released the first progress report of its nation-wide study of prolonged non-occupational illness.

Defining prolonged illness as any case of more than four weeks duration, the report covers the experience of 39,675 employees covering a continuous three-month period. This number represents only 10 per cent of the total group to be studied. The employees covered work for companies which have from 100 to 17,000 employees.

The council found that there was no marked difference in number of prolonged illnesses between men and women workers. The over-all average was 9 per 1,000 employees—which would be 36 per year. Male skilled workers had a prolonged illness rate markedly higher than that of the group as a whole with 710 work days lost per 1,000 skilled men. On a one-year basis, this would mean 2,840 skilled work hours lost to prolonged illness—or the equivalent of the full-time output of 12 employees!

Prolonged illness seemed quite equally divided between employees less than 45 years old and the older group, but duration of illness was longer for employees 55 or over—25 per cent of the latter remaining off the job for more than thirteen weeks.

Diseases of the digestive system caused the most long illnesses. Next came diseases of the respiratory system, fractures, neoplasms (malignant and benign), arthritis and rheumatism, in that order.



A PROVEN AID FOR MDs

The GRAY AUDOGRAPH is not an experimental machine for doctors. Hundreds in and around Wisconsin are using it with complete satisfaction, as a means of speeding up their office work and increasing the efficiency of their secretarial help.

A Few Users in Madison . . .

STATE MEDICAL SOCIETY
DIV. MENTAL HYGIENE, DEPT. OF PUBLIC WELFARE
AMERICAN BOARD OF INTERNAL MEDICINE
WISCONSIN DIV., AMERICAN CANCER SOCIETY
JACKSON CLINIC — VA HOSPITAL
ALBERT BONER, M.D. — WILLIAM LEWIS, M.D.
STUART McCORMICK, M.D. — RAY LUDDEN, M.D.

Let us demonstrate how this machine can serve you. No obligation . . . let us know what time and day would be most convenient. A representative is near your office.

JOHN NICHOLS, Inc.
541 N. BROADWAY — MILWAUKEE 2, WIS.

POINTS OUT TWO SERIOUS GAPS IN OUR EXISTING FOOD AND DRUG LAWS

Washington, Jan. 8.—Consumer protection under the existing food and drug laws suffers from two serious gaps, according to C. W. Crawford, commissioner of Food and Drugs for the Federal Security Agency.

Speaking to the National Food and Nutrition Institute in Washington in December, Mr. Crawford pointed out that there is widespread quackery which distorts facts of the real advances in nutritional science. This menaces health by encouraging ailing and uninformed persons to rely on nutritional nostrums instead of using readily available and adequate foods or seeking medical guidance.

Equally serious is the growing use of food additives which need not, under present food laws, be thoroughly tested from the standpoint of safety before going into foods sold to the public. Most manufacturers do such testing, but some do not.

Much of the nutritional quackery, according to Mr. Crawford, cannot be curbed under laws against false labeling and advertising. It is spread by self-styled authorities who base their claims on

1. theories on soil depletion and so-called organic gardening;
2. misconceptions regarding effects of food processing and cooking and
3. exaggeration of the extent and importance of "sub-clinical deficiencies" — or deficiencies which are suspected but cannot be clinically proven.

Mr. Crawford said that legislation to solve the food additive problem will go before the next Congress, but that quackery cannot be dealt with legally because it is so largely a matter of education. He urged nutritionists and all others interested in health to help expose quacks and faddists.

Staff Members Give to United Hospital Fund

Milwaukee, Jan. 2.—The charge that doctors shirk their community responsibilities has been well disproved by the staff physicians of two Milwaukee hospitals who contributed $158,750 to the United Hospitals Fund at the start of the drive in December.

The fund seeks to raise seven and a half million dollars to add about 400 new hospital beds in Milwaukee county. One hospital, St. Michael, will be replaced and a new St. Francis hospital will be built on the south side.

Dr. Ignatius J. Riccardi, head of the St. Michael staff committee for the fund, reported 15 subscriptions totaling $38,750, or an average of about $2,583 from about one third of the staff. His committee was the first to organize.

Dr. David J. Ansfield, committee chairman for the Mount Sinai hospital medical staff, reported 94 subscriptions totaling $120,000 after the first week's solicitation.

Committee chairmen who have been named at other hospitals include Dr. Frederick W. Madison, Columbia; Drs. Frederick C. Heidner and Chester C. Schneider, Deaconness and Dr. Carl W. Eberbach, Milwaukee.

COURT RULES . . .

(Continued from page 141)

He said that "at most there is a difference of opinion between the plaintiffs and the defendants concerning the violation of a penal statute by persons not parties to this action."

Judge Beilfuss pointed out that the real controversy is between the plaintiffs and the physicians and their employees, not between the pharmaceutical association and the board of pharmacy.

"The fact that doctors and their employees furnish dangerous drugs to patients may constitute some competition to the pharmacist," Judge Beilfuss stated, but he added that "the plaintiffs have no right to be immune from competition."

Concerning the pharmaceutical association's contention that the facts in the complaint were sufficient to grant the desired relief by mandamus, Judge Beilfuss said the only complaint against the Board of Pharmacy was that "they have not investigated and instituted prosecutions against third persons."

"Their refusal to so act is based upon the exercise of discretion in their official capacity. Mandamus does not lie to compel the manner in which discretion shall be exercised," Judge Beilfuss declared.

AMA Publishes a New Booklet for Public

"The AMAzing Story" is the title of a new booklet designed to acquaint lay people with the services rendered the general public by the AMA.

It presents an American family, the Typicals, and through them demonstrates just how the AMA is continually working, at local, county, state and national levels, for their improved health and safety.

The whole is presented in eight pages with a minimum of reading matter and a maximum of illustration. The booklet may be ordered through the State Medical Society, free of charge.

President's Commission Becomes Private One to Promote Use of Findings

Washington, D. C., Jan. 19—Dr. Paul B. Magnusen, chairman of the President's Health Commission, says his 15-member group, now dissolved officially, has become a private committee whose aim is to bring about wide distribution and public understanding of the Commission's 5-volume report.

Said Dr. Magnusen: "Our sole purpose is to educate the American public as to our findings. If a group of citizens decide to form an organization to further the aims of our report, that is all well and good. But we feel that our function as former commissioners is to do everything in our power to bring the basic information contained in our studies to the attention of the American people. Then it is up to them to act upon that information."

Rybutol Not Effective Against Old Age, Claim

Washington, Jan. 6.—The Federal Trade Commission has filed a challenge to claims that the drug preparation Rybutol is effective against advancing age.

The complaint charged misrepresentation in advertising claims that the preparation is "a competent and effective treatment for the symptoms of old age and the feeling of advanced age, including aches, pains, nervousness, fatigue, loss of energy and insomnia."

Proceedings of the Milwaukee Academy of Medicine, November 18, 1952

The Surgical Treatment of Bleeding Esophageal Varices

By ROBERT R. LINTON, M. D.*
Brookline, Massachusetts

MASSIVE bleeding from ruptured esophageal varices is a serious complication in patients with portal cirrhosis of the liver and Banti's syndrome. In fact it is one of the major causes of death in these two diseases. At the Massachusetts General Hospital, 128 patients were admitted because of bleeding esophageal varices during the years from 1934 to 1945 inclusive. Of these, 108 patients had portal cirrhosis of the liver and 20 had Banti's syndrome. None of these patients were treated surgically, since this was prior to any attempt to control bleeding esophageal varices, either by a direct approach on them or by the construction of some type of portacaval shunt. They were all treated conservatively and 97, or 76 per cent, died from all causes. There were 46, or 47 per cent, of the deaths directly due to hemorrhage alone from the esophageal varices, and in many of the other 51 patients who died, bleeding from these vessels played a major contributory role. Massive bleeding of this type is much more serious in patients with cirrhosis of the liver than in the younger age group with Banti's syndrome, because the former are more critically ill due to the diseased liver. A further analysis of this group of patients revealed that 54 per cent of the patients with cirrhosis of the liver were dead at the end of the year. This high mortality rate has been confirmed by statistical analyses of others.

Another recent survey of the problem at the Massachusetts General Hospital revealed that 99 patients were admitted because of cirrhosis of the liver during the five year period between 1946 and 1950 inclusive. In this group of patients portacaval shunts were performed in 33, or 33 per cent, of them and in 66, or 67 per cent, no surgical procedure was carried out. This was in large part due to the fact that 38, or 58 per cent, of the latter group died while in the hospital, and of utmost importance is the fact that hemorrhage from the esophageal varices played a major role in the deaths of 32, or 84 per cent, of these 38 patients. Further analysis revealed that exsanguination was the chief cause of death in 23, or 72 per cent, of them, and in the other 9, or 28 per cent, of the patients death was due to liver failure, which it is believed was undoubtedly precipitated by massive hemorrhage in each case. These figures demonstrate clearly that an early, effective, and safe means of controlling the ruptured esophageal varix at the time of acute hemorrhage is necessary if the immediate mortality from the bleeding is to be reduced, especially in those patients with cirrhosis of the liver.

The following emergency methods have been recommended: (1) Ligation of the splenic artery; (2) Ligation of the hepatic and splenic arteries; (3) Injection of the esophageal varices with a sclerosing solution; (4) An esophagogastrectomy or total gastrectomy; and (5) The use of gastric or gastro-esophageal tamponade by means of balloon tubes. Our experience has demonstrated that the only method in this group of five that has been of value as an emergency form of treatment is the last one. The other four have failed, either because they do not control the bleeding source or because the method carries too high a mortality rate. The chief criticism of the balloon tube is that, although it may control the hemorrhage temporarily, bleeding may start up again on removal of the tube before it has been possible to prepare the patient satisfactorily for a shunt procedure. For this reason a new method of controlling the bleeding esophageal varix at the time of acute hemorrhage has been utilized in conjunction with the balloon tamponade. This method is to expose the esophageal varices through a left transthoracic exposure, opening the esophagus just above the diaphragm, and carrying the incision down into the fundus of the stomach. The esophageal varices are readily demonstrated by this method. The bleeding source on a number of occasions has been visualized. The varices appear as longitudinal columns of greatly dilated veins which are sutured with catgut. It is possible in this way to obliterate them and thereby control the bleeding from them. Although this is not a definitive procedure to control the bleeding indefinitely, it does, in most instances, control the situation for a period of several months which, in a critically ill patient, permits sufficient time to prepare him for the major surgery of a shunt procedure.

Many procedures have been devised by various surgeons in an attempt to control the bleeding from esophageal varices, but none has been as effective as some type of portacaval shunt, anastomosing either the splenic vein to the left renal vein, or the portal vein directly to the inferior vena cava. These procedures are based on sound physiologic princi-

* From the Surgical Department of the Massachusetts General Hospital, Boston, Massachusetts.

ples, since the esophageal varices develop because of a portal bed block either in the liver or the portal venous system. As a result a state of portal hypertension develops with the formation of esophageal varices. The purpose of the shunt procedure is to bypass the site of block whether it be intrahepatic or extrahepatic. It is our opinion at the present time that the shunt procedure should be limited to those patients who have had a bleeding episode from their esophageal varices. It should never be done for ascites alone. Since many patients have this complication in addition to bleeding esophageal varices, every attempt should be made to clear the ascites by medical management before performing shunt surgery. There are few, if any, contraindications for shunt surgery in patients with extrahepatic portal bed block secondary to the so-called Banti's syndrome, since they are much better risks because their livers are essentially normal.

Liver function tests should be carried out to determine the liver reserve in each patient before performing shunt surgery. The following tests, in our opinion, are the most important: (1) The plasma albumin level should be above 3 Gm. per cent; (2) The prothrombin time should be within 10 per cent of normal; (3) The cephalin flocculation test should be no greater than 2 plus in 48 hours; (4) The bromsulfalein retention test should be within 10 per cent of normal; and (5) The quantitative van den Bergh test should also be within normal limits. It is of extreme significance that in 6 patients whose serum albumin level was below 3 Gm. per cent, the mortality rate was 85 per cent. Operation is not withheld if one or two of these tests indicated severe liver disease, except if the serum albumin level is below 3 Gm. per cent and, in such case, every attempt is made to bring it above this level, resorting to the intravenous use of human albumin if necessary.

From 1945 to April 1, 1952, 79 patients were subjected to some type of portacaval shunt. The results obtained have been extremely encouraging as the following statistical analysis indicates. A total of 83 shunts were performed in these 79 patients, since 4 patients, 3 with splenorenal anastomoses and 1 with an inferior mesenteric vein to left ovarian vein, had secondary hemorrhages, and in whom direct portacaval anastomoses were performed as secondary procedures. There were 59 end to side splenorenal shunts with splenectomy, or 71 per cent; 20, or 24 per cent, had direct anastomoses between the portal vein and the inferior vena cava, 16 of these were end to side and 4 were side to side; 4 other patients, or 5 per cent, had other types of shunts because it was impossible to perform either a portacaval or splenorenal anastomosis. Sixty-eight patients out of the group of 79 survived the construction of 71 shunt procedures, a mortality rate of 14 per cent. This immediate postoperative mortality has been greatly reduced during the last few years, since in the last 50 shunts that were performed there have been only 2 deaths, or a mortality rate of 4 per cent. A summary of the postshunt bleeding in these 78 patients reveals there has been only one death from esophageal hemorrhage, or a postshunt mortality rate from bleeding of 1.5 per cent. There are 5 others, or 7 per cent, of the 68 patients who survived the operative procedure and who have since died from various causes (from periods of 8 months to 4 years after the shunts were performed), but none of these died from bleeding. This leaves a group of 62 patients, or 78 per cent of the entire group, who are alive and, for the most part, well for periods varying from 6 months to 7 years. When compared with the natural course of the disease or those patients treated with conservative medical measures, this is without question a great improvement in the disease mortality rate.

1180 Beacon Street.

POSTGRADUATE COURSES ANNOUNCED BY UNIVERSITY OF MICHIGAN

The department of postgraduate medicine at the University of Michigan Medical School has scheduled a series of short review courses for practicing physicians. The schedule for the first part of 1953 is as follows:

Internal Medicine

Diseases of the Heart	March 16–20
Electrocardiographic Diagnosis	March 23–28
Recent Advances in Therapeutics	March 30–April 2
Diseases of Blood and Blood-Forming Organs	April 6–10
Metabolism and Endocrinology	April 6–10
General Practice	April 13–24
Ophthalmology	April 20, 21 and 22
Roentgenology, Diagnostic	April 6–10

Further information may be obtained by writing to H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, University Hospital, Room 2040, Ann Arbor, Michigan.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

A 27 year old white male was admitted to the hospital in December 1950. At that time he entered because of increasing and persistent swelling of feet, ankles, and legs, and swelling of the abdomen. This had been noted about one month prior to admission and had responded to no form of therapy. Besides these complaints, the patient stated that he was frequently short of breath (with or without exertion) and had recently been awakened by paroxysmal nocturnal dyspnea.

The patient had been a known diabetic for many years and, at the time of his admission to the hospital, was being maintained on 50 units of protamine zinc insulin. About one year previously a constant albuminuria developed. He had difficulty in vision and on admission stated he could only discern light and shadows with his right eye.

The past history revealed measles, mumps, and whooping cough. The family history revealed that both parents, one brother, and two sisters were living and well. A history of diabetes mellitus was present within the family.

Systemic review was essentially negative for other complaints referable to the cardio-respiratory system. No symptoms or complaints of gastrointestinal disorders were elicited. The patient stated he had recently noted oliguria with frequency (and scanty urine) and nocturia.

On physical examination he appeared fairly well nourished and well developed but pallorous. He was cooperative, alert, and in no apparent distress at the time of examination. The pulse was 100; blood pressure 184/110 mm. of mercury; respirations 16; and temperature 98.6 F.

The head and neck were essentially negative. The pupils reacted to light and accommodation. Funduscopic examination showed hemorrhage and white patches on the right with no choking of the disk. The chest was symmetrical. The lungs revealed râles in both bases, but were otherwise clear to percussion and auscultation. The heart was enlarged to the left and a "tic-toc" rhythm was present. The abdomen was slightly distended but soft. No fluid wave was elicited; no masses or viscera were palpated. The lower extremities showed a 4 plus edema. Reflexes were physiological. The body weight on admission was 158 pounds.

The red blood cell count was 4,200,000; hemoglobin content was 13 Gm.; white blood cell count 12,700, with 3 per cent stabs, 59 per cent segmented, 35 per cent lymphocytes, and 3 per cent eosinophils. The urine was clear and acid in reaction; the urinary specific gravity was 1.005; albumin was 1 plus; sugar was absent. The sedimentation rate was 85 mm. in one hour (Westergren); total serum protein 8.4 Gm.; and albumin-globulin ratio 1.6/1.0. Several "cancer tests" gave the following results: Huggins-Jensen, 2 plus; methylene blue reduction, 3 plus; brilliant cresyl blue, 4 plus; heat coagulation, 3 plus; and skin test, 2 plus.

An electrocardiogram on admission showed heart strain probably of coronary origin. An x-ray of the chest showed cardiac enlargement to the left, with patches of increased density in both bases and a small amount of fluid in the left chest.

The patient was placed on low fluid intake and given a diabetic salt-free diet. Within 48 hours, a 2 pound weight loss was noted and edema of the extremities was down to 1 plus. He was also given digitalis, rutorbin, and protamine zinc insulin. The blood sugar levels varied greatly (40 to 360 mg. per hundred cubic centimeters.) On two occasions they fell to 40 to 45 mg. per hundred cubic centimeters. With the second episode of hypoglycemia the patient became apprehensive, the skin was cold and clammy, and diaphoresis was present. This was apparently relieved by 5 ounces of orange juice. A daily check of fluid intake and output was kept. The output exceeded intake on three successive days, with the highest difference between the two being 1,000 milliliters. The weight gradually fell during this period, reaching 142 pounds just prior to discharge. The peripheral edema also disappeared.

During his stay, the nonprotein nitrogen varied from 46 to 75 mg. per hundred cubic centimeters. One creatinine level was 2.8 mg. per hundred cubic centimeters. Urinary reducing substances ranged from negative to 4 plus.

The patient was readmitted in February 1951. Since leaving the hospital, he had been confined to his bed, but occasionally sat up in a chair. The edema of the lower extremities had returned; the abdomen had become greatly distended; and the shortness of breath was now almost constant. He had frequent episodes of acute paroxysmal nocturnal dyspnea and could lie flat in bed for only short periods of time. When examined on this admission, he was dyspneic while sitting in bed.

The physical examination was essentially the same as on the previous admission with these few added

* From St. Joseph's Hospital and the Department of Pathology, Marquette University School of Medicine, Milwaukee; **Dr. M. C. F. Lindert** and **Dr. Samuel Rosenthal**, clinicians; **Dr. G. W. Sengpiel**, radiologist; and **Dr. D. J. Carlson**, pathologist.

LIBRARY OF THE COLLEGE OF PHYSICIANS

features. The abdomen was greatly distended, and there was 4 plus edema of the lower extremities. The liver edge was palpable 3 fingerbreadths below the costal margin, and a gallop rhythm was present. As previously, congestive râles were heard in both bases and x-ray showed increased density in both bases.

The red and white blood cell counts were within normal limits. The urine was straw-colored and acid in reaction; urinary specific gravity was 1.010; albumin was 3 plus; 1 to 3 red blood cells and 8 to 10 white blood cells were present. The nonprotein nitrogen was 57.1 mg. per hundred cubic centimeters.

As on the previous admission he was placed on a salt-free diabetic diet. He was given digitalis, sedation, and ammonium chloride daily. One milliliter of mercuhydrin was given on the day of admission, which was followed by 1,825 milliliters output of urine within the next 24 hours. However, following that, urine output ranged from 500 to 1,250 milliliters.

Two days after this admission the patient complained of epigastric pain and refused to eat his noon meal. About 6:30 p. m. on that same day, he became very apprehensive and dyspneic with profuse diaphoresis and cold, clammy skin. The following morning he had a similar episode and was given 500 milliliters of 5 per cent glucose. A second intravenous infusion of glucose was started, but was discontinued because of abdominal pain, difficulty in breathing, increasing apprehension, dyspnea, and sweating. The right chest was tapped that evening and 1,350 milliliters of fluid removed. Improvement was noted but was only temporary. In less than an hour all had returned. He was now coughing frequently and expectorating a frothy, mucoid sputum. He was somewhat improved the following day. The blood pressure was 150/120 mm. of mercury. The patient vomited and complained of "weight" over the precordium. He expired shortly afterward.

Dr. G. W. Sengpiel: The film taken on Dec. 27, 1950 showed marked cardiac enlargement, predominantly of the left ventricle. In the left base there was definite fluid, probably 700 to 800 milliliters. With the elevation of both diaphragms and the other findings of congestive cardiac failure, the cause of the diaphragmatic elevation was probably abdominal ascites. The lungs presented the typical picture of passive congestion. There were also irregular patches of increased density within the lung fields indicating superimposed bronchopneumonia. These areas could also represent pulmonary infarction. The films taken six weeks later also showed elevation of the diaphragm. The heart was approximately the same size, and fluid was present in both pleural spaces (1,000 milliliters to each side). The areas of increased density were apparently cleared, supporting the probability that they were a pneumonic process.

Dr. M. C. F. Lindert: Dr. T. R. Murphy and I took care of this patient during the last six months of his life. He had one previous hospitalization elsewhere during which the same sequence of events occurred.

An interesting point in his past history was the onset of the diabetes at about the age of seven years. He had never taken care of his diabetes except after he was married, approximately one year before his death. Prior to that time he refused to take any care of himself both in respect to his general physical condition and the diabetes. During the last year of his life the diabetes was not a great problem. However, during one hospitalization the blood sugar levels were very fluctuant and bizarre. They not only varied widely but did not fit the clinical picture. The sugar levels were low when the patient was not hypoglycemic clinically; and conversely, they were hyperglycemic when he was clinically hypoglycemic.

We had no knowledge as to the duration of his hypertension. He was already hypertensive when we first saw him. At that time he did not have any eyeground changes. Albuminuria was present then and ranged from moderate to severe. Clinically, we did not feel that he had Kimmelstiel-Wilson's disease for several reasons. Firstly, he probably was too young; secondly, he was too severe a diabetic; and thirdly, we think it is extremely difficult to unequivocally make a diagnosis clinically of Kimmelstiel-Wilson's disease.

We felt that the edema which presented itself during the last four or five months was chiefly due to cardiac failure. The patient was treated intensively for the cardiac failure with rapid diminution of the edema. He went into relapse when he returned home. We had no control over diet and sodium intake while he was at home. While he promised faithfully that he would follow recommended treatment, he had abused himself for so long that he felt he could continue to do so. And he did.

Dr. Samuel Rosenthal: I think this case is important, not because it presents a difficult diagnostic problem, but rather because it focuses our attention on the changing course and causes of death of diabetes mellitus. Prior to insulin, diabetics generally died from one of three causes: (1) coma; (2) intercurrent infection such as pneumonia, carbuncles, and septicemia; and (3) renal infections. With the advent of insulin it was hoped that these complications could be avoided. Perhaps now the diabetic could live a normal life expectancy with reasonable deductions for the diseases that beset other individuals. Unfortunately this hope has not been entirely realized. We still find many diabetics developing degenerative changes. In fact they have become subject to a new and different group of diseases or complications, as compared to their course in the pre-insulin era. This patient finally succumbed to certain of these complications that we feel are related to the diabetic state.

What are the pertinent data in this case? The patient was a young man, only 27 years of age. He

had had diabetes for 20 years or more. The diabetes was poorly controlled because of indifference by the patient. He was admitted to the hospital on several occasions because of shortness of breath, edema of the extremities, and terminally because of difficulty of vision in one eye. He was not admitted in coma; he had no acute infection; and there was no gangrene of the extremities. In fact he came in with none of the complications common in the pre-insulin era. Either his diabetes had changed in character or lesions of an altered nature had developed. The symptoms which he presented were not those directly related to diabetes mellitus. Diabetes mellitus alone does not cause edema, shortness of breath, albuminuria, and oliguria.

The edema and shortness of breath are basically symptoms of cardiac disease or failure. Treatment for cardiac failure in this case was followed by dramatic relief from symptoms. Albuminuria and oliguria are most often due to renal disease. I feel that this patient had both cardiac and renal disease. The problem is to relate, if possible, the diabetic state and the combined renal and cardiac disease. We must determine whether the cardiac and renal lesions were independent and coincidental or could be correlated with the diabetes. I believe we can demonstrate a relationship between the cardiorenal disease and the diabetes.

Before we attempt this let us review the pertinent findings in the physical examination. He had hypertension (184/110 mm. of mercury), cardiac enlargement, pleural effusion, and edema of the ankles. The cardiac enlargement indicates that the hypertension was of some duration. It may have been present for one year, two, or five. I would suspect it would be around three to five years. He also had râles in his chest and roentgenologic evidence of congestive cardiac failure.

From these physical findings we cannot say this was purely hypertensive cardiac disease with failure. There may have been an element of renal disease. The edema that was present could be due to some form of renal as well as cardiac disease.

The laboratory can aid in resolving this problem. There were several pertinent laboratory findings that support the presence of severe renal disease. There was nitrogen retention: the nonprotein nitrogen varied from 46 to 75 mg. per hundred cubic centimeters, and the creatinine was 2.8 mg. per hundred cubic centimeters. Secondly, we have other evidence of renal failure. In spite of albuminuria, the specific gravity of the urine was low (1.005 to 1.010). As you know, studies on renal physiology show that the kidneys excrete a certain amount of solids and fluid through glomerular filtration, tubular filtration, and reabsorption. The amount of solids excreted is relatively constant, *e.g.* urea, creatinine, chlorides, etc. The specific gravity normally varies with the fluid intake. A normal kidney should be able to concentrate and dilute urine depending upon the fluid intake. Specific gravity is high with restricted fluid intake and low with increased fluid intake. The larger the amount of urine excreted, the lower the specific gravity. However, this patient excreted very small amounts of dilute urine with a low specific gravity indicating inability to excrete solids.

I would like to emphasize that when a patient has albumin or sugar in the urine, one should use a correction factor to obtain the true specific gravity. This is important because we give considerable attention to urinary specific gravity. When sugar is present one should subtract 0.004 from the observed specific gravity for every 100 Gm. of glucose in 100 milliliters of urine. When albumin is present, one subtracts 0.003 from the observed specific gravity for every 100 Gm. of albumin per hundred milliliters of urine. This patient had albuminuria and glycosuria which would lower the values given here. This would mean that the specific gravity was almost that of water. We have, therefore, tangible evidence of renal disease, namely nitrogen retention, albuminuria, and low specific gravity of the urine.

An interesting feature in this case is the normal total serum protein reported as 8.4 Gm. with a relatively normal albumin-globulin ratio. I do not understand why this patient's blood protein was not down when he was losing albumin in the urine. This peculiar phenomenon might be explained by the fact that in terminal renal disease excretion of albumin may fall. After all, if the glomerular filtrate is almost absent, albumin would not escape through the filter. It, therefore, remains in the blood stream.

There were alterations of the serum protein, however, of a qualitative nature. The sedimentation rate was elevated and a battery of "cancer tests" were positive. I do not think this man had cancer; I would be very much surprised if he did. At the time of his admissions, several cancer tests were being done at St. Joseph's Hospital as an experimental evaluating project. In both the sedimentation rate and "cancer tests," abnormal protein (qualitatively altered) was responsible for these "positive" results. The alpha globulin is related to the sedimentation rate and abnormal albumin in the "cancer tests."

There were a few other findings of importance that point to generalized vascular disease. The electrocardiogram indicated cardiac strain, most likely due to vascular disease, namely, coronary insufficiency. There were white patches and hemorrhage within the retina of the right eye. This man had, therefore, cardiac and renal disease both of which may or may not be related to the diabetes mellitus. The most likely causative lesion is arteriosclerotic vascular disease affecting the heart and kidneys.

To further resolve this problem let us review the question of vascular sclerosis. Arteriosclerosis may assume one of three forms. It may involve the large vessels and aorta, *i.e.* atherosclerosis. Flat, elevated, and frequently ulcerated plaques containing cholesterol are seen beneath the intima. The medial coat

may be affected, so-called Monckeberg's sclerosis in which calcification and thickening of the media are the prominent features. The last or third form is arteriolar in character with involvement of the intima, *i.e.* the inner layer of small arteries and arterioles. It is accepted that all of these forms are more common in diabetics than in other individuals. In this patient both the cardiac and renal disturbances were probably on a vascular basis due to coronary sclerosis and renal nephrosclerosis. In fact, no other concept other than vascular sclerosis can satisfactorily explain the combined cardiac and renal disease as seen in this case.

At this point, I would like to say that it is still unsettled as to whether these vascular complications are due to uncontrolled diabetes or are an integral part of a prolonged diabetic state. There certainly appears to be an increased vulnerability of the vascular tree with the diabetic tendency. This patient belonged in the group of poorly controlled diabetics. The clinical course as presented supported poor control as a factor in the acceleration, if not actual precipitation, of vascular disease in diabetes mellitus. However, there are a goodly number of diabetics who have always been well controlled with good medical care, adequate insulin, and proper diet, in whom serious vascular disease also develops. We cannot forget this for it is the single discouraging feature of insulin therapy.

What form of combined cardiovascular and renal disease did this patient have? He had arteriolar disease within vessels of the retina. The renal disease was also arteriolar involving small arteries and preglomerular arterioles. Larger arteries, such as the coronary arteries, were also affected. All of this points to generalized arteriosclerosis involving large and small vessels of several organs.

In respect to the renal disease a logical explanation would be arteriolar sclerosis. Such a change would be consistent with the development of hypertension and renal failure. This could also be Kimmelstiel-Wilson's disease; and I believe that this change is present. As you know, in 1936 Kimmelstiel and Wilson reported 8 cases of what they called intercapillary glomerulosclerosis. A characteristic nodular alteration and hyalinization is seen microscopically within the capillary tufts, and clinically there is hypertension, albuminuria, and renal failure. I must admit that making this diagnosis is hazardous. One cannot accurately predict this histologic alteration within the kidneys before death. However, this patient had some of the essential clinical findings for this diagnosis.

The terminal event in this case was most probably myocardial infarction. It is most difficult even in a 27 year old patient to overlook the severe epigastric pain, apprehension, nausea, and electrocardiographic changes.

In summary, this was a case of a 27 year old diabetic who had uncontrolled diabetes for 20 years or more. Vascular disease developed involving all units of the vascular tree, *i.e.* capillaries, arterioles, and larger arteries. The principal organs affected were the heart and kidneys, with resultant severe coronary sclerosis and nephrosclerosis complicated by cardiac and renal failure. He finally succumbed with an acute myocardial infarction as the most likely terminal event.

Dr. W. A. D. Anderson: I would like to know more exactly why you added Kimmelstiel-Wilson's disease?

Doctor Rosenthal: The cases reported have exhibited the symptoms presented here, namely, hypertension, albuminuria, renal failure, and uncontrollable diabetes mellitus. I really made the diagnosis on presumptive grounds, realizing that it does occur in just such instances as presented here. There is no specific symptom or finding one can use to make the diagnosis of Kimmelstiel-Wilson's glomerulosclerosis.

Dr. D. J. Carlson: The external examination revealed slight abdominal distention; the liver edge was palpated 3 to 4 fingerbreadths below the right costal margin. There was edema of the lower extremities, prepuce, and scrotum. Internal examination revealed abundant fluid within both pleural spaces and pericardial effusion (150 milliliters). The heart was enlarged and weighed 460 Gm. The myocardium of the anterior wall and apex was very thin (5 mm.) yellow-gray, and fibrous. Aneurysmic dilatation of the left ventricle was prominent. A friable, gray-red thrombus was attached to the endocardium overlying the aneurysm. The coronary vessels showed severe sclerosis and stenosis but no definite thrombus was found. There were numerous atherosclerotic plaques within the aorta. The lungs were heavy (right 980 Gm., left 1,020 Gm.). The cut surfaces were brown and very moist. Large amounts of brown, frothy fluid poured from the surface. Several small blood vessels contained antemortem thrombi. Within the adjacent lung firm, triangular, deep-red nodules of infarction were seen. The liver weighed 2,000 Gm. It was brown and the cut surface presented a "nutmeg" appearance. The spleen weighed 170 Gm. and was flabby and soft. The pancreas was small; it weighed 50 Gm. and

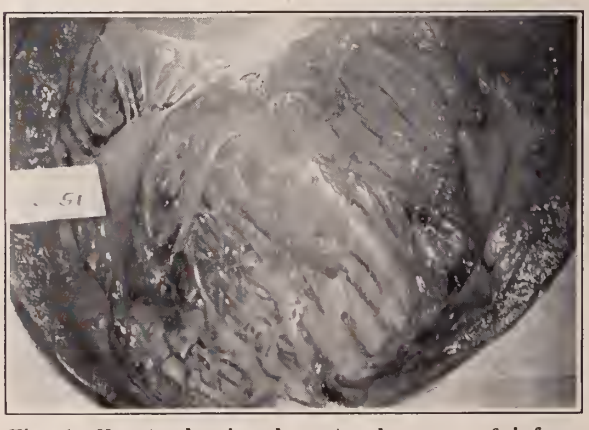


Fig. 1—Heart, showing hypertrophy, area of infarction involving apical region of left ventricle, with dilatation and mural thrombosis.

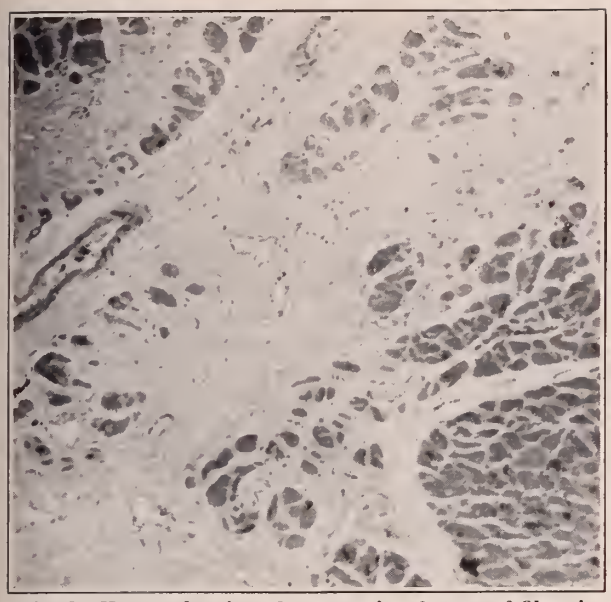


Fig. 2—Heart, showing the extensive degree of fibrosis due to the coronary sclerosis.

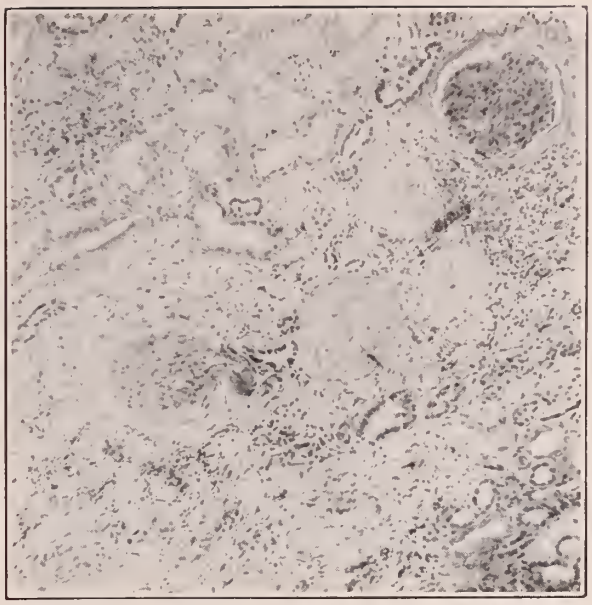


Fig. 4—Kidney, showing the hyalinization of glomeruli as a result of the vascular sclerosis.

Fig. 3—Kidneys, showing the finely granular surfaces.

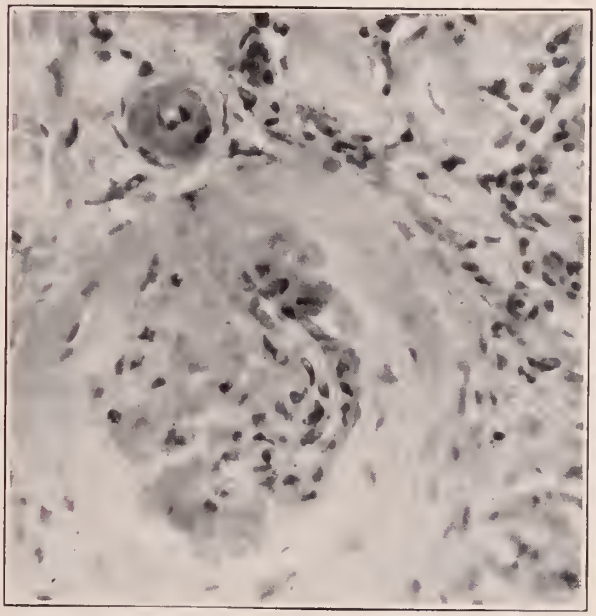


Fig. 5—Glomerulus of kidney showing sclerosis of entering arteriole and fibrosis.

appeared atrophic. The adrenal glands presented a normal gross appearance. The kidneys weighed 120 and 150 Gm. respectively. Their external surfaces were pale and finely granular. The cut surfaces were cloudy. The parenchymal markings, however, were distinct and the cortices were thin. The intestinal tract was not unusual. The head was not examined.

Microscopic examination of tissues confirmed the impression obtained from the gross tissues. The pericardium was thickened, edematous, and infiltrated by chronic inflammatory cells. The myocardium showed focal and diffuse fibrosis. Other areas showed recent infarction as evidenced by hemorrhage, necrosis, and neutrophilic infiltration. Coronary sclerosis was extensive. The lumens were slit-like and eccentrically placed. Subintimal plaques, medial fibrosis, and calcification were prominent. The lungs revealed extensive edema and congestion. The alveoli were completely filled with fluid and pigmented "heart failure" cells. In several areas a hyalin-like eosinophilic membrane lined slightly thickened alveolar walls. Areas of infarction were also seen. The liver showed passive congestion. Within the pancreas the islets of Langerhans were fibrotic and hyalinized. There also was interstitial fibrosis of the pancreas accompanied by lymphocytic infiltration. The adrenal glands and spleen showed vascular congestion and arteriolar sclerosis. The kidneys revealed partial to complete hyalinization of glomeruli. The preglomerular arterioles and afferent vessels were thick and hyalinized, in many there was complete occlusion of the lumens. Tubular atrophy, interstitial fibrosis, and lymphocytic infiltration were also seen. Larger renal arteries showed intimal thickening and medial fibrosis. In a few

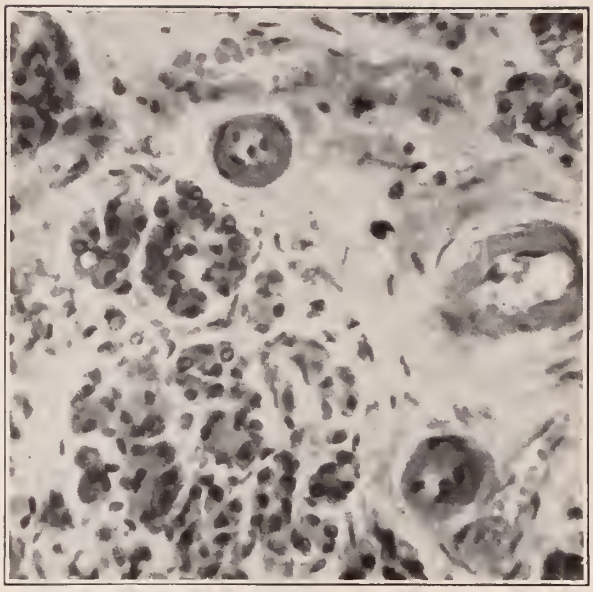


Fig. 6—Pancreas, showing arteriolar sclerosis and fibrosis.

areas the glomeruli presented nodular hyalinization, suggesting intercapillary glomerulosclerosis. It was not definite or characteristic, however, of Kimmelstiel-Wilson's disease. In general the vessels of all organs showed a fairly marked sclerosis.

The anatomical diagnoses were as follows: severe coronary sclerosis with stenosis; infarction of the myocardium with aneurysm of the anterior wall; mural thrombus of left ventricle; pulmonary thrombosis and infarction; severe passive congestion and edema of lungs; arteriolar and arterial nephrosclerosis; hydrothorax and hydropericardium; pancreatic fibrosis; hyalinization and fibrosis of islets of Langerhans; and generalized arteriosclerosis.

As Doctor Rosenthal has pointed out, this patient showed generalized vascular sclerosis. Atherosclerosis of the aorta was marked. Coronary sclerosis was very severe. Renal sclerosis was also pronounced. That this patient had Kimmelstiel-Wilson's disease of the kidneys is improbable. While suggestive changes were seen, the basic pathology is that of nephrosclerosis. One can easily explain all the observed histologic alterations on an arterial and arteriolar sclerosis alone.

The pulmonary changes were interesting, especially the thick hyalin-like eosinophilic membranes that lined the alveolar spaces. Such a change is described as occurring in uremia and has been called "uremic pneumonitis." Of course, the severe edema and brown discoloration of the lungs and "heart failure" cells were due to a profound cardiac failure. The hydrothorax was also a manifestation of cardiac failure.

We agree, therefore, with Doctor Rosenthal that this patient, although very young, had severe sclerotic changes within his entire vascular tree. All organs were affected, namely the kidneys, liver, spleen, pancreas, and others. Unfortunately, healthy coronary circulation and renal circulation are essential for continued life. The renal changes were sufficient to produce uremia; the coronary sclerosis was responsible for the terminal myocardial infarction.

The association of vascular sclerosis and diabetes mellitus rests on a secure foundation. Many diabetics die of cardiovascular diseases such as coronary occlusion, cerebral sclerosis, and hemorrhage; and they do so at an earlier age than a corresponding non-diabetic group. The severe nephrosclerosis seen in this case is common. Other renal lesions include acute and chronic pyelonephritis and papillary necrosis. We believe, and therefore agree with Doctor Rosenthal, that the course of diabetes mellitus has been altered by insulin therapy. A whole new group of diseases has, as it were, been thrust upon the diabetic to plague and distress him. We might add that adequate insulin therapy, diet, and proper living have not appreciably, if at all, retarded the progression of these complications.

Dr. M. C. F. Lindert: I want to repeat that this man was too young and his diabetes too severe for Kimmelstiel-Wilson's disease. The patients with glomerulosclerosis usually have mild diabetes. In some, no diabetes was detected clinically. In those cases it is felt that they were sub-clinical diabetics.

Dr. Timothy Murphy: Is it difficult to histologically distinguish between very mild forms of amyloidosis of the kidney and Kimmelstiel-Wilson's glomerulosclerosis?

Dr. W. A. D. Anderson: The changes, except for the affinity by amyloid for specific stains such as Congo red, may be strikingly similar. In fact certain stages of nephrosclerosis also simulate Kimmelstiel-Wilson's disease histologically. As Doctor Murphy has suggested, there have been several studies in which it has been claimed that a certain number of individuals with Kimmelstiel-Wilson's disease do not have diabetes mellitus. Dr. Arthur C. Allen, particularly, has taken issue with this. He feels that the change seen in such cases is not truly a glomerulosclerosis of the Kimmelstiel-Wilson type, and that the change is rather strictly a pathognomonic lesion.

REFERENCES

1. Allen, A. C.: The Kidney: Medical and Surgical Diseases. New York, Grune & Stratton, 1951, pp. 425–448.
2. Allen, A. C.: So-called intercapillary glomerulosclerosis. A lesion associated with diabetes mellitus; morphogenesis and significance, Arch. Path. 32:33–51 (July) 1941.
3. Bell, E. T.: A postmortem study of vascular disease in diabetics, Arch. Path. 53:444–455 (May) 1952.
4. Kimmelstiel, P., and Wilson, C.: Intercapillary lesions in the glomeruli of the kidney, Am. J. Path. 12:83–98 (Jan.) 1936.
5. Lukens, F. D. W., and Dohan, F. C.: Experimental pituitary diabetes of five years' duration with glomerulosclerosis, Arch. Path. 41:19–24 (Jan.) 1946.
6. Robbins, S. L.: Renal lesions in diabetes mellitus. Bull. New England M. Center 10:78–83 (April) 1948.
7. Warren, S.: Pathology of Diabetes Mellitus. Philadelphia, Lea & Febiger, 1938.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Some 1952 Developments in the Drug Therapy of Infectious Diseases

There was considerable argument during the year regarding the intimate nature of the association of fungus infections with the use of the broad spectrum antibiotics—aureomycin, terramycin, chloromycetin—but none of the intriguing questions were definitively answered. Evidence was presented, however, that much of the reported localized moniliasis is not actually that, and furthermore that superinfection with fungi is a less serious matter than the development of resistant streptococcal and staphylococcal strains. Some preliminary evidence was offered indicating that certain esters of paraben may be helpful in preventing corpus albicans outgrowth during aureomycin therapy, but much additional study of the subject is required. Definitive laboratory studies have revealed combinations of antibiotics to be sometimes more effective than a single one, but convincing evidence has not been produced that this is often true in human disease except for tuberculosis, brucellosis, bronchiectasis, and sometimes subacute bacterial endocarditis due to an enterococcus. An extremely interesting report during the year was that of synergistic action of sulfonamides and penicillin, which confirmed in man the earlier observations in experimental animals. Evidence was fairly well completed during the year that both penicillin and streptomycin actions are interfered with by the wide spectrum antibiotics in experimental infections, though we are still not certain of the clinical significance of these findings.

In at least one carefully conducted study during the year there was produced evidence that lower aureomycin dosage than heretofore employed is effective in bacterial pneumonias, which may be expected to operate effectively against both the cost of broad spectrum antibiotic therapy and the gastrointestinal reactions sometimes induced by these drugs. It was reported during the year that only the duration of the period of absorption of aureomycin from the gastrointestinal tract is affected by ordinary dosage increases, not the rate of absorption of the drug.

Experimental animal work during the year strongly indicated that persistence of penicillin in the tissue fluids after the titer in the peripheral circulation has become negative is responsible for the efficacy of infrequent injections of fairly large amounts of this drug. Investigation showed also that, if one considers in the reckoning the trillions of units of penicillin nowadays prescribed, the incidence of penicillin reactions has fallen strikingly. There was certainly definitely evident in the year's antibiotic literature a trend toward changing sensitivity of organisms, but the true significance of these laboratory observations for clinical medicine was not made clear.

Aplastic anemia in association with the use of chloramphenicol (chloromycetin) was reported sufficiently often during the year to constitute a serious hazard in connection with the use of this drug.

When the status of streptomycin therapy in skeletal tuberculosis was reviewed during the year it developed that, if all the "rules" are faithfully observed, the picture is a quite cheerful one.

Of course an outstanding development in drug therapy during 1952 was the introduction of the hydrazine derivatives of isonicotinic acid in tuberculosis, but one cannot expect as yet accurate assessment of the place of these new agents in the total picture.

Reports during the year on the efficacy of sulfone therapy in leprosy indicated that real progress is finally being made in the treatment of this disease.—HARRY BECKMAN, M. D.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Chicago, May 7, 8, and 9, 1953, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than February 15, 1953. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin,
E. M. Dessloch, Prairie du Chien, Chairman.

Benefits for Medical Care

Wisconsin Physicians Service provides benefits for medical care **only** in hospitalized cases. Under the new contracts, medical care benefits are paid according to the fee schedule purchased by the subscriber. Persons who purchased the "A" schedule are eligible for medical care benefits of $10 for the first day of hospitalization, $5 for the second and third days, and $4 per day thereafter up to 30 days from the first day of hospitalization. The "B" schedule provides benefits of $8 the first day, $4 the second and third days, and $3 thereafter.

Non-surgical services provided by a physician for hospitalized participants can be considered as medical care. For example, electroshock therapy for hospitalized patients commands a medical benefit under the WPS contract. Treatment of ivy poisoning is considered medical care.

Emergency treatment of heat exhaustion and food poisoning are considered to be medical care rather than trauma, and therefore call for medical care benefits.

It should be emphasized that the payment of any medical care benefit for WPS participants is conditioned on the person being a bed patient in the hospital.

Surgical Benefits of Special Interest

Emergency surgery: There is an important difference in benefits allowed for surgery under the old and new WPS contracts. The old contract provided benefits for emergency surgical treatment of accidental injuries **only** when the services were performed within 24 hours after such injury .

The new contract provides benefits for surgical services whenever performed. There is no time limit on surgery in connection hours after such injury.

Sprains: Under both the old and the new contracts, benefits are provided for sprains, abrasions, and contusions. These conditions are considered surgical and payment for treatment is made according to the fee schedule.

Unna boot: WPS provides a benefit for the application of an Unna boot in connection with the treatment of the varicose ulcer.

Pneumothoraces: Benefits for multiple pneumothorax procedures are provided by WPS up to the maximum fee allowable for a single surgical procedure. Thus, the maximum benefit available for pneumothoraces is $150 under the old schedule, $200 under the "B" schedule, and $300 under the "A" schedule.

Injections

With certain exceptions, benefits are **not** provided for hypodermic injections and intravenous medications under WPS coverage. Injections for colds, hay fever, and measles are examples of the type of treatment for which benefits are not available.

However, the Commission on Prepaid Plans has given favorable consideration to some injections which are recognized by the profession as acceptable procedures in lieu of surgery. Examples of procedures for which surgical benefits are payable are lumbar puncture and the treatment of varicose veins, hemorrhoidectomy, and herniotomy by the injection method.

Waiting Periods

Cesarean section and miscarriage are considered to be maternity services. Therefore, the patient must have held Blue Shield family coverage for 9 months before benefits for these procedures are payable.

Ectopic pregnancy is considered a surgical procedure and no waiting periods are required.

Benefits and Exclusions

No benefits are provided for removal of tonsils or adenoids by deep x-ray therapy.

Spinal barbitage is not a recognized procedure of the profession, and therefore no benefits are payable.

Simple fractures may command Blue Shield benefits regardless of the type of treatment; e.g., cast, splint or reduction.

Benefits are payable for myelograms.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 FEBRUARY, 1953 Number 2

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Jonesville
J. W. Gale—Madison
P. A. Midelfort—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS
THE COUNCIL

W. H. Castella—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kosten—Beloit
E. M. Desslach—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCorey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point
R. G. Arvesan—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galosinski—Milwaukee
E. L. Bernhort—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Cosper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Post-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

H. K. Tenney—Madison
D. W. Ovitt—Milwaukee
Elwood Mason—Milwaukee
Chalmer Dovee—River Falls
G. E. Farkin—Menasha

★

ADVERTISING ADVISORY COMMITTEE

A. L. Tatum—Madison
N. A. Hill—Madison
Harry Beckman—Milwaukee
Mr. Roy T. Rogotz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

What's the Use?

The article in this issue by Maxine Bennett, M. D., relating to the Wisconsin Hearing Conservation Program, leaves one with mixed emotions as to whether these programs are actually worth while or whether the wrong approach is being used. In spite of the vast amount of time, effort, and money spent on this particular survey, less than one-half of the recommendations were carried out by the patients. (In Racine County 44 per cent and St. Croix County 43 per cent.)

The author's last conclusion that "a good many failures to carry out the recommendations are due to the fact that parents have not been convinced of the benefits to be gained" is worthy of serious thought. If this be true, and we have no reason to believe that it is not, then the approach to conservation of hearing by this type of survey is sorely lacking. It may be that the family doctor has not been made an integral part of a program such as this and he should be. The impersonal touch of a state-wide program in which an outside doctor, unknown to the patient, makes the examination and makes the recommendation might be immeasurably helped if the family doctor took some part in it and backed up the recommendations that have been made. It also might be a good idea to spend a little time with the family doctors of these patients, satisfying them that the recommendations are well worth while, or else to drop the whole thing as not being worth the effort expended.

Rx for Better Doctors

The article by Earl Thayer, our public information director, in the *Wisconsin Alumnus*, October 1952, entitled "Rx For Better Doctors" is so well done we commend it to the rest of the profession for perusal. Earl gives a thumbnail sketch of the way the University medical school and the State Society team up to keep the average doctor fully informed on all the advances of medicine. We think it is an excellent piece of public relations work, very factual, and well worth the reading by both the average Wisconsin reader and those of us in the medical profession who know about the program but have not quite realized how extensive a job has been done.

Copies of the article may be obtained by writing to the State Medical Society of Wisconsin, 704 East Gorham Street, Madison, Wisconsin.

Comments from the Wisconsin Press

Doctors Pulling for Nurse's Training

The Brown-Kewaunee-Door County Medical Society has set up a plan which should insure the continuation of the nurse's training schools at the St. Mary's and Bellin hospitals here. The society appears to have made a statesmanlike approach to the problem. It proposes to meet all of the state requirements. . . To assist in recruiting students, the society plans a student loan fund to assist with tuition fees and incidental expenses where needed.

Committees of the society will shortly meet with representatives of industry, civil defense, nursing groups and civic organizations to enlist their interest in this problem. While professional people are directly concerned here, the general public has by far the most important interest. Trained nurses are indispensable to the health and welfare of any community. . .

The effort of the medical society to insure the continuation of this important service is certainly commendable.—GREEN BAY PRESS-GAZETTE, Dec. 17, 1952.

* * *

Shortage of Nurses and Teachers

Wisconsin and the nation face a shortage of nurses and teachers that grows worse instead of better. There is no promise of an increased supply to meet the rising need, either. . .

The nurses' associations in the state are trying hard to get girls into nursing training; also to get former nurses to help fill the gap. The hospitals are working constantly to get nurses and girls to train as nurses. The State Medical Society of Wisconsin is giving all out support. . .

The women's auxiliary of the State Medical Society recently put on a statewide recruiting program. Some units of the auxiliary . . . are offering scholarships and loans for student nurses. Other units . . . have distributed nurse recruitment literature to pupils in 500 Wisconsin high schools. Doctor's wives visited principals and counselors in high schools, explaining the need and opportunities for girls in the field of nursing, and asking help in recruiting.

Both the teaching and nursing professions should attract girls. There are no finer and more useful careers. But push is needed in the fields of teaching and nurses recruiting. . . To get results, there will have to be more action, especially from groups such as the teachers' association and parent-teacher associations and the medical groups.—DELAVAN ENTERPRISE, Dec. 31, 1952.

* * *

A Sober Look at Health Programs

Government aid for paying medical and hospital bills is once more before the public. . . The outgoing Democratic administration failed to put across its program, but the issue is not dead. Two or three matters connected with any health insurance plan ought to be kept in view. . .

There is the element of compulsion. Federal law now requires the deduction from payroll checks of funds for income taxes and for old age insurance benefits. . . Obviously, the plan is not one which can be extended too far. . .

A second element is the certainty of federal control if the federal government contributes funds. . .

Finally we come to the question of quality of medical and hospital service, and to the morale of those who furnish it. The question mark here, under any system of insured or subsidized medicine, is a big one.

If there is sufficient public demand for government medical service . . . then we shall have it . . . and we will all help to pay the bill. . . What is important in the months ahead is that we all understand the step, and that we make a decision on so important a matter with our eyes wide open.—JANESVILLE DAILY GAZETTE, Dec. 20, 1952.

* * *

Public Panic Helps Nobody

Wisconsin doctors are getting worried about a new disease: public panic. It seems to express itself in floods of telephone calls and inquiries springing from fear that the patient is going to lose his doctor to the draft. . .

The State Medical Society figures most of the alarm stems from a Selective Service order requiring physical exams for 635 physicians without previous military duty. That doesn't mean that all 635 are going to be snatched into the armed services overnight. . .

An official medical advisory committee to Selective Service makes recommendations to local boards on which doctors should be considered essential. Any doctor finally called will be given ample notice —time to tell his patients and to help them make arrangements for continued medical care.—WISCONSIN STATE JOURNAL, Dec. 16, 1952.

. . . . The President's Page . . . .

The Medical Practice Act

OF GREAT interest and importance to the medical profession and the people of Wisconsin are many of the bills being considered during the session of the state legislature now in progress. Health service is the number one goal as far as our profession is concerned and we are dedicated to its promotion and protection. With the cooperation of the entire medical profession, in unity of thought and purpose, a sound legislative foundation for the practice of the health professions in Wisconsin can be achieved.

Several bills now in the legislative hopper have to do with revision of the Medical Practice Act in the hope of modifying and improving this act.

We are operating under a law that is antiquated. For example, the present statutes require that the membership of the State Board of Medical Examiners include three allopaths and two eclectics—"schools" of medicine which have long since ceased to exist.

The Committee on Public Policy has spent more than a year studying the present law and detailing its revision. It has met with members of the present Board of Medical Examiners. The Council of the State Medical Society has deliberated the conclusions of the committee with the result that some 20 proposals for medical education and licensure in Wisconsin have been endorsed for legislative action.

One of these proposals—requiring the Board of Medical Examiners to maintain a permanent office in Madison with the state health officer as secretary-treasurer of the board—has met with bitter opposition from some segments of the profession. The position of the committee and the Council was explained at legislative conferences in 14 cities of the state held for the purpose of detailing the proposals for a revised Medical Practice Act. The Council believes that the board should maintain offices in Madison for the convenience of applicants, for the safekeeping of records, and for the availability of legal counsel from the attorney general who is the board's attorney.

With the state health officer as secretary-treasurer, the board would have the services of a full-time administrative staff located in the capitol city with ready access to permanent records and immediately available for consultation. The nature and volume of the board's business affairs are such that full-time attention to administrative details is a requirement for the proper functioning of the board in the public interest.

Opponents of this proposal have felt, and very strongly so, that the secretary should be a practicing physician, and they have communicated with other societies and legislators regarding their stand.

An honest difference of opinion is American. It is democratic, and it is healthy. Let us not, however, lose sight of the over-all picture and sacrifice unity to the point where a new statute would not be better for the people of Wisconsin than the inadequate, antiquated law now on the books.

J. C. Griffith M.D.

OFFICIAL CALL FOR

Scientific Exhibits

★

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6–7–8

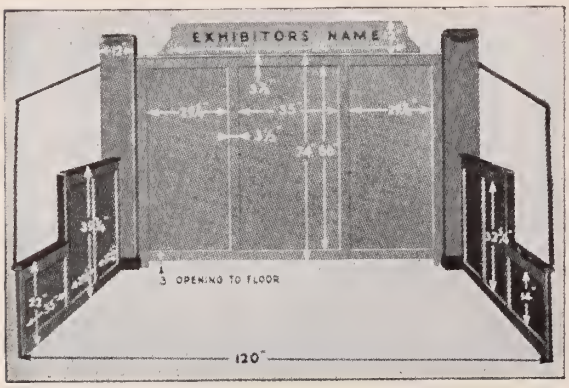
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1953 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1953 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of gray wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to S. A. Morton, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6-7-8

Fill Out and Mail to:

S. A. MORTON, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (attach 200 word description to this blank): _____

3. The standard booth is 10′ wide and 9′ deep. _____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be used? If so will you furnish them? _____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

TWO LECTURES SCHEDULED IN MARCH BY VETERANS ADMINISTRATION

The Neuropsychiatric Staffs of the Veterans Administration Center, Wood, and the Regional Office, Milwaukee, have scheduled two lectures for the month of March. Both talks will begin at 8:00 p.m. in the Ward Memorial Theater, Wood.

On March 3, "Childhood Schizophrenia" will be presented by Dr. Lauretta Bender, professor of clinical psychiatry, New York University College of Medicine. The second lecture will be given on March 10 by Dr. D. Ewen Cameron, director of the Allan Memorial Institute of Psychiatry, Montreal, Canada. The title of his talk will be "Certain Loci Favorable for Therapeutic Interference."

REMINDER: *On Regional Teaching Programs*

If you have not already done so, sign up for the regional meetings listed below which are nearest your home. Registration $6.00, including dinner (For March 26 meeting at Neenah, where wives will attend, joint dinner reservations are $9.00. The same applies to the June clinics in northern Wisconsin).

On March 25 the Marshfield Clinic will start with a "wet clinic" at 11:00 a.m., with Doctor Ebert reviewing rheumatic fever patients.

MARCH

TUESDAY, MARCH 24: Beaver Dam (Elks Club)

WEDNESDAY, MARCH 25: Marshfield (Nurses Auditorium and Charles Hotel)

THURSDAY, MARCH 26: Neenah (Theda Clark Hospital and Valley Inn) COUNCILOR DISTRICT MEETING

Robert C. Parkin, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Recent Advances in the Prevention and Treatment of Rheumatic Fever: Richard V. Ebert, M.D., Professor of Medicine, University of Minnesota Medical School, Minneapolis

Practical Aspects of Congenital Heart Disease in Children: James Du Shane, M.D., Assistant Professor of Pediatrics, Mayo Foundation Graduate School, University of Minnesota Medical School

Diagnosis and Management of Bleeding in Early Pregnancy: M. Edward Davis, M.D., Joseph Boliver DeLee Professor of Obstetrics and Gynecology, Lying-in Hospital, University of Chicago

Geriatric Surgery: Erwin R. Schmidt, M.D., Professor and Head of Department of Surgery, University of Wisconsin Medical School, Madison

APRIL

TUESDAY, APRIL 14: West Bend (Thoma's Resort, Little Cedar Lake)

WEDNESDAY, APRIL 15: Shawano (Bilmay Hotel)

THURSDAY, APRIL 16: Stevens Point (Whiting Hotel) COUNCILOR DISTRICT MEETING

George E. Collentine, Jr., M.D., Milwaukee, Moderator

(Program from 2:00–5:00 p.m.)

A Clinical Approach to Common Infections: Burton A. Waisbren, M.D., Clinical Instructor of Medicine, Marquette University School of Medicine, Milwaukee

Office Gynecology: Herbert E. Schmitz, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago

Traumatic Surgery as It Concerns the General Practitioner: John T. Reynolds, M.D., Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago

Treatment of Arrhythmias: Richard Langendorf, M.D., Associate Attending Physician and Research Associate, Cardiovascular Department, Michael Reese Hospital, Chicago

MAY

WEDNESDAY, MAY 13: Delavan (Lake Lawn Resort)

THURSDAY, MAY 14: Sheboygan (Pine Hills Country Club)

FRIDAY, MAY 15: Green Bay (Elks Club)

Joseph W. Gale, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Metabolic Problems in General Practice: E. S. Gordon, M.D., Associate Professor of Medicine, University of Wisconsin Medical School, Madison

Recent Advances in Obstetric Practice: John Parks, M.D., Professor and Head of Department of Obstetrics and Gynecology, George Washington University, Washington, D. C.

The Problem of Chronic Cystic Mastitis with Special Reference to Its Relation to Carcinoma: Robert Elman, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis

The Convulsive Disorders in Childhood: M. G. Peterman, M.D., Head of Department of Pediatrics, Milwaukee County Hospital, Milwaukee

JUNE

WEDNESDAY, JUNE 24: Hayward (Radio Joe's Inn)

THURSDAY, JUNE 25: Minocqua (Minocqua Country Club)

PHYSICIANS' WIVES ARE INVITED TO ATTEND THESE CLINICS. SPECIAL ENTERTAINMENT WILL BE PROVIDED.

E. H. Jorris, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Some Newer Concepts Concerning the Prevention and Treatment of the Late Toxemias in Pregnancy: John W. Harris, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison

Recent Advances in Pediatrics of Importance in General Practice: Charles May, M.D., Professor and Head of the Department of Pediatrics, State University of Iowa College of Medicine, Iowa City

The Clinical Significance of Vascular Changes in the Skin: William Bean, M.D., Professor and Chairman of the Department of Internal Medicine, State University of Iowa College of Medicine, Iowa City

For Reservation Blank See Page 45—Advance Reservation Desired

Dramamine® in Vertigo

The remarkable relief afforded by Dramamine in motion sickness has led to studies of its possible value in allied conditions.

Dramamine apparently depresses hyperstimulation of the vestibular apparatus. Thus it is an effective means of relieving the nausea and vertigo which characterize dysfunctions of the middle ear.

Accepted Uses for Dramamine
(BRAND OF DIMENHYDRINATE)

MOTION SICKNESS

NAUSEA and VOMITING associated with
- pregnancy
- drugs (certain antibiotics, etc.)
- electroshock therapy
- narcotization

VESTIBULAR DYSFUNCTION associated with
- streptomycin therapy

VERTIGO in
- Ménière's syndrome
- hypertensive disease
- fenestration pracedures
- labyrinthitis
- radiation sickness

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE *Research in the Service of Medicine*

Prescribe Journal-advertised products and you prescribe the best.

COMMITTEE *Concentrates*

WISCONSIN VETERANS MEDICAL SERVICE AGENCY NOVEMBER 21

MDs present: J. S. Supernaw, chairman, J. L. Moffett, Otto Dittmer, W. A. Fischer, S. E. Sebastian, E. O. Ronneburger

There was discussion about the fact that in some cases the information given on Forms 200 was repetitive. The committee recommends that physicians adequately describe the services they render veterans, because these reports are made a part of the permanent record of the veteran. Both the agency and Veterans Administration officials presented problem cases to the committee for their evaluation.

COMMISSION ON PREPAID PLANS DECEMBER 13–14

MDs present: E. M. Dessloch, chairman, Robert Krohn, N. A. Hill, J. T. Sprague, T. D. Elbe, H. E. Kasten, J. W. Truitt, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, W. C. Stewart, H. B. Christianson, G. W. Carlson, R. C. Parkin

Approved a revised PSR form providing a copy for the doctor . . . First day medical care benefits payable when coverage commences for an infant after the fourteenth day of life . . . Authorized study of first day surgical benefits for newborn . . . Approved policies for continuation of coverage of subscribers on strike, layoff, leave of absence . . . Medical care benefits payable before usual pre- and after usual post-operative care within contract limitations . . . Accidental injuries classified as surgical claims . . . Approved execution of an interplan transfer agreement to permit continuous coverage to persons transferring between plans, provided conditions are met . . . Acted on a number of routine matters.

GRIEVANCE COMMITTEE DECEMBER 18

MDs present: R. E. Fitzgerald, chairman, H. W. Wirka, E. D. Sorenson, F. A. Nause

MATERNAL MORTALITY STUDY CONFERENCE DECEMBER 30

MDs present: T. A. Leonard, John Harris, F. J. Hofmeister, Alice Watts, R. J. Sanderson, E. D. Wilkinson, Amy Louise Hunter, Carl Neidhold, W. O. Paulson, Joseph Egan, Homer Carter, W. V. Luetke, George C. Hank, Robert McDonald, M. A. Krembs, George S. Kilkenny, F. N. Pansch, and Florence Duckering

Purpose of meeting to launch Maternal Mortality Study and to acquaint members of the Study Committee and Interviewers Committee with procedures to be followed. Agreement reached as to whether or not family should be interviewed (decision *not* to do this); whether or not the attending physician should be invited to report his opinions on the case (decision: "yes"); and how the identity of the patient, doctor, and hospital should be concealed. . . . Small committee charged with completion of details (which has been done, and the project is now under way, with Dr. George Hank, Madison, as chairman of the interviewers and responsible for the arrangement of contacts with the attending physicians). Work reported to Division on Maternal and Child Welfare on January 31 and approved. . . . Findings at end of year to be summarized for report to the entire profession.

COUNCIL ON SCIENTIFIC WORK JANUARY 7

MDs present: T. O. Nuzum, J. W. Gale, S. A. Morton, P. A. Midelfart, R. S. Baldwin, J. S. Hirschboeck, M. G. Rice, and W. S. Middleton

Primary purpose of meeting to crystallize plans for scientific programs to be offered in connection with 1953 Annual Meeting. Specialty programs reviewed and final determinations made as to speakers to be invited. Specialty programs to be held as follows: October 6 (Tuesday)—Anesthesia, Internal Medicine and Psychiatry, and Pediatrics; October 7 (Wednesday)—Cardiac and Pulmonary Diseases, Pathology, Obstetrics and Gynecology, Orthopedics; October 8 (Thursday)—Radiology, Surgery, Ophthalmology and Otolaryngology. (To date here are some of the headliners who have accepted: John W. Pender, Rochester, Minn. and W. O. McQuiston, Peoria, Anesthesia; Joseph Aub, Boston, and Paul Schallenberger, Sayre, Pa., Internal Medicine;

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY-MANSFIELD DIVISION

George A. Perera, New York, Cardiac and Pulmonary Diseases; Brig. Gen. E. DeCoursey, Washington, D. C., Pathology; Lawrence R. Wharton, Johns Hopkins, OB & Gyn; and Robert Janes, Toronto, Surgery. More "big names" are in the process of being signed up, and it looks like a top notch program!). . . . Each day there will be demonstrations in anatomy, gross pathology, OB manikin demonstrations, fractures and application of casts, and therapy of the cerebral palsied child. . . . **The dates are October 6–7–8, so mark them on your calendar.**

SUB COMMITTEE ON CANCER JANUARY 8

MDs present: R. P. Welbourne, P. B. Blanchard, A. C. Taylor

Purpose of meeting to determine what type of professional and lay education programs should be conducted. . . . Decision to have special cancer clinics next November devoted to uterine cancer, cancer of the lung, oral cancer, and cytologic examinations. Plan to invite dentists to attend dinner meeting with speaker on oral cancer as evening program. Steps being taken to secure outstanding speakers in the fields chosen. Tentative plans call for clinics on November 17, 18, 19. Possible sites: Eau Claire, Wausau, and Appleton or Neenah. . . . Also decided to prepare short pamphlet which physicians can make available to patients explaining smears and biopsies and their importance to early detection of cancer. The popularity of the leaflet "What You Can Expect of A Cancer Examination" prompts committee to suggest companion piece.

COMMISSION ON STATE DEPARTMENTS JANUARY 10

MDs present: T. W. Tormey, Jr., Chairman, John D. Steele, John A. Schindler, Ray G. Piaskoski, H. A. Sincock, Robert F. Purtell, E. H. Pawsat, H. W. Carey, E. D. Schwade, T. L. Tolan

The first meeting of the Commission was organizational . . . to appoint membership of divisions and outline basic studies and projects for the year. Guests included Dr. E. H. Jorris, State Board of Health; Mr. Frank Powell, Department of Public Instruction; Mr. Adrian Towne, State Board of Vocational and Adult Education; Mr. John Tramburg, Department of Public Welfare . . . speaking on the various activities and problems in their departments.

COMMITTEE ON PUBLIC POLICY JANUARY 11

MDs present: J. M. Sullivan, chairman, John K. Curtis, J. M. Schroder, J. A. Enright, J. C. Griffith, H. Kent Tenney

Committee approved drafts of bills for submission to the legislature . . . a proposal to register physical therapists in Wisconsin, modeled after Minnesota law and others . . . present law licensing masseurs would be repealed, but those already licensed could continue to practice . . . Clarification of present law respecting expert testimony of out-of-state physicians . . . The difficult problem of providing for a special educational certificate, to individuals holding a degree in medicine, for training in hospitals approved for internship or residency purposes . . . The purpose is to provide opportunities solely for further education, and the law is intended in no way to license permit-holders to actually engage in practice of medicine . . . The problem is complicated by technical aspects, such as malpractice liability, authority to sign vital statistics records, and order medication by hospital employees, etc. . . . Other subjects considered included proposal of the Wisconsin Society of Chiropodists "clarifying" their licensing law . . . proposal of the Wisconsin Psychological Association to certify psychologists and in 1955 to define and limit the field of clinical psychology . . . Conforming pharmacy laws in the state to federal legislation . . . Introduction of legislation to provide state aid on a limited basis to county or multiple county health departments, to enable the state to set up demonstration units.

COMMITTEE ON CIVIL DEFENSE JANUARY 15

MDs present: M. J. Musser, chairman, J. S. Wier, E. A. Bachhuber, E. P. Ludwig, K. E. Lemmer, A. L. Van Duser, E. F. White, J. H. Wishart, and C. K. Kincaid

Reviewed progress of state civil defense program. State and city civil defense authorities asked to work through county medical society for aid in planning medical aspects of civil defense. County societies should be asked to name physicians to take part in the establishment of medical teams. About ⅓ of the supplies needed for 100 medical teams in Wisconsin are now stored at Camp Williams. When the remainder is delivered, the supplies will be packaged in units to be located near each team. Approval given to manual on the operation of mobile medical teams.

INTERIM COMMITTEE JANUARY 17

MDs present: J. C. Griffith, chairman, S. E. Gavin, J. M. Bell, R. E. Galasinski, H. Kent Tenney

A study has been undertaken concerning the advisability of securing malpractice insurance on a group basis. State-wide interest is indicated, but it is a ticklish problem, and requires more study before recommendations can be offered . . . With the acquisition of more IBM equipment, committee recommending to Audit & Budget Committee and Council proposal to effect mechanisms January 1953, for recording data on physicians . . . with 80 combinations of information available, it will eliminate

He Asked Permission to Stay

Major William E. Barber, USMC
Medal of Honor

EIGHT THOUSAND weary marines lay besieged at Yudam-ni; three thousand more were at Hagaru-ri, preparing a breakthrough to the sea. Guarding a frozen mountain pass between them, Major Barber, with only a company, held their fate in his hands. Encirclement threatened him; he was ordered to withdraw. But he asked permission to stay, and for five zero-cold days the company held the pass against attack. The Major, badly wounded, was carried about on a stretcher to direct defense. When relief came, only eighty-four men could walk away. But Major Barber's action had been decisive in saving a division.

"I know," says Major Barber, "that you at home realize what hard jobs our sons and brothers are doing in America's armed forces. Maybe you *haven't* realized that you're *helping* those men—whenever you invest in U. S. Defense Bonds. True, Bonds are personal financial security for you. But they also strengthen our economy—to produce the good arms and food and medical care that make our men secure."

Peace is for the strong!
For peace and prosperity save with
U. S. Defense Bonds!

Now E Bonds pay 3%! Now, improved Series E Bonds start paying interest after 6 months. And average 3% interest, compounded semiannually when held to maturity! Also, all *maturing* E Bonds automatically *go on* earning—at the new rate—for 10 *more* years. Today, start investing in Series E Defense Bonds through the Payroll Savings Plan.

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

manual reporting and make available lists and reports often requested . . . Reconsidering physician enrollment on group basis for Blue Cross–Blue Shield plans, with study of number of counties already enrolled . . . Approved for recommendation to Council resolution to establish section on medical history, dues to be used for medical museum at site of Fort Crawford Military Hospital.

DIVISION ON TUBERCULOSIS AND CHEST DISEASES JANUARY 29

MDs present: John Steele, L. W. Moody, J. W. Gale, Milton Feig, Henry Anderson, A. A. Pleyte, Einar Daniels, and George Owen

First meeting of the division since appointment by Commission on State Departments on January 10. Discussion directed to TB patients in mental hospitals, examination of school personnel (agreed to survey schools to see how many now requiring chest x-ray of all employees), service of furnishing chest films to MDs on request, and preparation of material which could be sent to GPs when patients with suspicion of TB reported, to enlist their support in a better program of follow-through. Agreed to invite Doctor Neupert to next meeting to give members better understanding of source of funds for TB control, and how funds spent. Also decided to invite State Supt. George Watson to meeting to discuss possible changes in regulations in respect to physical examinations of school personnel, to give better protection to students from contacts with teachers who have TB.

DIVISION ON MATERNAL AND CHILD WELFARE JANUARY 31

MDs present: R. F. Purtell, Amy Louise Hunter, G. S. Kilkenny, John D. Wilkinson, Dean D. Willson, Thomas V. Geppert, F. J. Hofmeister, and T. A. Leonard

As first meeting of division of Commission on State Departments since appointment on January 10, one object of meeting was to acquaint new members with functions of division and projects of immediate concern. Special attention directed to Maternal Mortality Study and methods to be followed. Decided to initiate some local hospital studies in relation to fetal and neonatal mortality, and suggested that pathologists be invited to have a member sit in on all meetings, as members felt that more attention must be directed to autopsies in these fields . . . Refused to approve suggestion that division suggest types of non-obstetric cases which can be safely housed in maternal ward if all beds not filled with OB patients. Felt danger in any relaxation of rule would condemn such practice . . . Recommended inclusion of exhibit at 1953 Annual Meeting on pathology related to fetal and neonatal deaths . . . suggested reprinting of breast feeding pamphlet, but not having it sent to all expectant mothers as routine service of State Board of Health. Rather make the pamphlet available to MDs who would pass it on to patients at their own discretion.

RELATED ACTIVITIES

Members in and around Milwaukee should note that on March 12 there will be an important conference on "Rehabilitation" held at VA Hospital, Allen–Bradley, and the Milwaukee Athletic Club between 10:00 a. m. and 9:00 p. m. Main speaker will be Frank Krusen, M. D., Mayo Clinic, who is a top leader in rehabilitation, nationally and internationally . . . Free lunch, so line up to the right! . . .

The monthly clinics are going over very well, with an average attendance of between 40 and 50 at each conference. Bad weather spoiled the meeting in Eau Claire on January 15, but even at that nearly 50 members braved the storm and attended. . . . The "Code of Necropsy" which has been in process of production for nearly two years is finally on the press! Reason for delay: getting the official nod of both hospital associations, the funeral directors group, and the pathologists. Now all are agreed on the content, so we wind up that project with a sigh of relief!

Wisconsin well represented at Industrial Health Congress of A. M. A. in Chicago, January 20–22, with Doctors Dorchester, Sulick, and Sander in attendance. Many references to Wisconsin program of "in-plant clinics" and spot radio announcements in relation to industrial health.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1953 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1953 meeting of the society. Essays submitted in this competition must be received not later than March 1, 1953. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, % Dr. Herbert H. Thomas, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

This is one of a series of advertisements designed to explain the Councils' functions to you.

"Does this product have A. M. A. Council Acceptance?"

The first question many physicians ask the detail man when a new product is presented.

If the detail man can answer "Yes," you know that the composition of the product has been carefully verified, that members of the Council have checked the clinical evidence, the label, the claims and agreed that the product merits your confidence. You can, of course, ask your own questions, and make your own decision about using any product. However, you save yourself a vast amount of time—and gain the benefit of an expert, fact-finding body whose work protects you and your patient. Therefore, why not use Council Acceptance as your guide?

No physician could afford to devote much time and study to every new product. Your Council on Pharmacy and Chemistry renders this service for you, freely. Nowhere else in the world are there groups that perform the functions so ably served by the A. M. A.'s Council on Pharmacy and Chemistry, the Council on Foods and Nutrition and the Council on Physical Medicine and Rehabilitation.

Food and drug companies cooperate with the Councils on a free and voluntary basis. The Councils serve you by giving assurance that the product bearing it has undergone a careful examination. Ask your detail man, "Is this product Council Accepted?"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON PHYSICAL MEDICINE and REHABILITATION AMERICAN MEDICAL ASSOCIATION

Society Proceedings

Barron–Washburn–Sawyer–Burnett

Meeting at the Elks Club in Rice Lake on December 9, the members of the Barron–Washburn–Sawyer–Burnett County Medical Society elected the following officers for the coming year: *Dr. H. M. Templeton*, Barron, president; *Dr. W. F. Vaudreuil*, Rice Lake, vice-president; *Dr. M. H. Sahs*, Spooner, secretary-treasurer; *Dr. R. W. Adams*, Chetek, censor; *Dr. N. A. Eidsmoe*, Rice Lake, delegate; and *Dr. C. J. Strang*, Barron, alternate delegate.

Brown–Kewaunee–Door

Officers of the Brown–Kewaunee–Door County Medical Society were elected at a meeting at the Elks Club in Green Bay on December 11. *Dr. S. M. Mokrohisky*, named president-elect a year ago, took office as president succeeding *Dr. J. L. Ford*. Named president-elect to take the presidency next year was *Dr. G. B. Merline* of De Pere. Others named were *Drs. J. W. Nellen*, vice-president, *G. M. Shinners*, secretary-treasurer; and *Louis Milson*, censor.

The society appointed the following committee chairman to serve for 1953: Program, *R. M. Waldkirch*, De Pere; Public Relations, *L. D. Quigley;* Legislative and Public Health, *A. J. McCarey;* Grievance, *O. W. Saunders;* Cancer, *L. C. Miller;* Fee Schedule, *O. W. Saunders;* Hospital Relations, *W. A. Killins;* Library, *Louis Milson;* Industrial Health, *D. E. Dorchester*, Sturgeon Bay; Pension, *P. R. Minahan;* Veterans Affairs, *F. O. Kuehl;* Rural Health, *E. W. Witcpalek*, Kewaunee; Blood Procurement, *J. L. Ford;* Vision and Hearing Conservation, *E. G. Nadeau;* and Nursing School, *G. B. Merline*, De Pere.

Unless otherwise noted all of the physicians are from Green Bay.

Calumet

On November 18 the Calumet County Medical Society met at the Old Mill in Hayton for its annual election of officers. *Dr. F. P. Larme* of New Holstein was re-elected president, and the following physicians were named to serve with him: *Drs. J. W. Goggins*, Chilton, vice-president; *J. M. Guthrie, Jr.*, Brillion, secretary-treasurer; *N. J. Knauf*, Chilton, censor; *E. W. Humke*, Chilton, delegate; and *A. C. Engel*, New Holstein, alternate delegate.

The meeting was preceded by a dinner with wives of the members as special guests.

Chippewa

Dr. B. F. Rahn of Cornell was elected president of the Chippewa County Medical Society at that group's annual meeting held November 18 at the Hotel Northern in Chippewa Falls. Other officers elected include *Drs. W. F. Janc*, vice-president; *C. A. Kemper*, secretary-treasurer; *W. C. Henske*, delegate; and *J. J. Sazama*, alternate delegate. With the exception of Doctor Rahn, all of the officers are from Chippewa Falls.

Dodge

Meeting at St. Joseph's Hospital in Beaver Dam on November 18, the members of the Dodge County Medical Society heard an address by *Dr. T. V. Geppert* of the Dean Clinic, Madison. Doctor Geppert's talk was entitled "Infant Feeding" and was followed by an informal discussion by the members of the society present.

Fond du Lac

The November meeting of the Fond du Lac County Medical Society was held at the Elks Club in Fond du Lac on November 20. *Dr. D. W. McCormick* arranged for the speaker of the evening who was *Dr. P. J. Collopy*, instructor of orthopedic surgery at Marquette University. Doctor Collopy chose "Complications of Amputations" as the subject of his talk.

The annual Christmas party of the society was held at the South Hills Country Club in Fond du Lac on December 18. *Drs. E. W. Vetter* and *L. J. Keenan*, both of Fond du Lac, were co-chairman for the dinner party, which was followed by an evening of entertainment and dancing. Forty members and their wives attended.

Jefferson

O. H. HANSON, M. D.

Meeting at Chauncey's in Pipersville on November 20, the members of the Jefferson County Medical Society heard a talk by *Dr. R. F. Schilling* of Madison. The subject of his talk was "Anemia."

At the annual business meeting, held at the Meadow Springs Country Club in Jefferson on December 18, the society elected *Dr. O. H. Hanson*, Ft. Atkinson, president for the coming year. Other officers chosen at this meeting were *Drs. E. J. Netzow*, Lake Mills, vice-president, and *H. N. Hunsader*, Ft. Atkinson, secretary-treasurer.

Refresh...add zest to the hour

The institution is located on Oconomowoc Lake, two miles east of Oconomowoc and 28 miles west of Milwaukee on U.S. Highway 16.

There are 25 acres of landscaped grounds and all the buildings for patients are fireproof.

Senile — *Convalescent* — *Nervous*

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

For further information write or phone
G. R. Love, M. D.
Physician in Charge
Oconomowoc, Wis.

Green Lake–Waushara

The Green Lake–Waushara County Medical Society held its last quarterly meeting for 1952 at the Berlin Memorial Hospital on December 11. The meeting began with a Christmas dinner for the entire hospital staff, the board of directors, and the members of the society and their wives, and was followed by the election of officers for the coming year. *Dr. A. C. Theiler*, Princeton, is the new president; *Dr. D. J. Sievers*, Berlin, is vice-president; and *Dr. L. S. Shemanski* of Wautoma was elected secretary-treasurer.

The guest speaker for this occasion was Mr. W. J. Foster, a representative of the Linde Air Products Company. Mr. Foster spoke on the installation and method of operation of the Berlin hospital's new oxygen system.

Kenosha

Dr. Gilbert J. Schwartz was installed as head of the Kenosha County Medical Society on December 4, at a meeting held at the Elks Club in Kenosha. He succeeds his brother, *Dr. H. L. Schwartz. Dr. R. M. Block* was named president-elect. Other officers elected at this meeting include *Dr. Helen A. Binnie*, secretary; *Dr. D. N. Goldstein*, delegate; and Dr. L. H. Lokvam, alternate delegate. All of the officers are from Kenosha.

A panel discussion on the Kenosha Orthopedic School was a feature of the scientific portion of the meeting. Panel participants were Frank Powell, Madison, director of the Bureau of Handicapped Children of the Wisconsin Department of Public Instruction; Otto Steffensen, principal of the orthopedic school; and G. M. Phelan, chairman of the Kenosha County Crippled Children and Polio Board. The speakers presented the history, organization, aims, and future plans of the crippled child program in the state. The role of the family doctor was particularly stressed.

La Crosse

E. J. McCORMICK, M. D.

The La Crosse County Medical Society met with the Seventh Councilor District at an open dinner meeting in the ballroom of the Hotel Stoddard in La Crosse on November 17. Dr. Edward J. McCormick, president-elect of the American Medical Association, was the principal speaker and presented an excellent talk on phases of American Medicine and the continued threat of Communism from without. During the program, *Dr. J. J. Satory*, president of the county society, presented a scroll to *Dr. Gunnar Gundersen*, in recognition of Doctor Gundersen's accomplishments in the field of organized medicine.

Guests at the meeting included *Drs. A. J. McCarey* of Green Bay, *T. C. Hemmingsen* of Racine, and Mr. C. H. Crownhart, secretary of the State Society. Wives of all members were special guests at the meeting.

At another recent meeting of the La Crosse Society, the following officers were elected for 1953:

President—*Dr. L. M. Gorenstein*
Vice-President—*Dr. J. C. Harman*
Secretary-Treasurer—*Dr. H. W. Harris*
Delegate—*Dr. J. J. Satory*
Alternate—*Doctor Harris*

Lafayette

At a business meeting of the Lafayette County Medical Society on December 2, *Dr. L. L. Thompson*, Argyle, was named president for the coming year. Serving with him will be *Drs. N. A. McGreane*, Darlington, vice-president; *Dr. L. J. Unterholzner*, Blanchardville, secretary-treasurer; and *Dr. D. J. Garland*, Shullsburg, delegate.

Lincoln

Dr. Walter Lewinnek, Merrill, will head the Lincoln County Medical Society during 1953, as the result of an election held at the December meeting of the organization. Other members named to office were *Drs. W. C. McCormick*, Tomahawk, vice-president; *J. D. Millenbah*, Merrill, secretary-treasurer; *R. G. Baker*, Tomahawk, delegate; and *K. A. Morris*, Merrill, alternate.

Manitowoc

Endorsement of an infirmary at the Waumegesako Council Boy Scout Camp at Pigeon Lake was given by the Manitowoc County Medical Society at a dinner meeting held at noon on November 20 at Wellhoefer Grill in Manitowoc. It is planned that individual contributions from members of the county medical society and from the county dental society will finance the new "sick bay." Following the business meeting, *Dr. N. A. Bonner* showed slides of his recent European trip.

On December 4, the annual dinner for members of the society and their wives was held at Dill Resort, English Lake. *Drs. W. H. Scherping, R. G. Strong*, and *E. C. Cary* were in charge of the dinner and entertainment.

Marathon

The new president of the Marathon County Medical Society, *Dr. H. W. Christensen*, Wausau, was installed at the December 3 meeting, held at the Wausau Club in Wausau. *Dr. H. M. Bachhuber*, Athens, was named president-elect and other new officers include the following: *Dr. J. M. Foerster*,

secretary; *Dr. E. P. Ludwig*, delegate; and *Dr. D. M. Green*, alternate delegate. All are from Wausau. Elected to the board of censors were *Drs. H. A. Schulz*, Edgar, *E. E. Flemming*, Wausau, and *A. W. Hoessel*, Mosinee; to the program committee were *Drs. George H. Stevens* and *C. M. Yoran*, Wausau, and *W. A. Knoedler*, Mosinee; and to the public health and legislative committee were *Drs. H. H. Fechtner, A. H. Stahmer*, and *G. J. Schroth*, all of Wausau.

Polk

Members of the Polk County Medical Society met on October 16 to elect the following officers:

President—*H. A. Dasler*, Amery
Vice-President—*F. B. Riegel*, St. Croix Falls
Secretary-Treasurer—*G. B. Noyes*, Centuria
Assistant Secretary—*L. J. Weller*, Osceola
Delegate—*L. O. Simenstad*, Osceola
Alternate—*V. C. Kremser*, Amery
Censor—*F. L. Whitlark*, Amery

On December 18, *Dr. and Mrs. R. G. Arveson*, Frederic, were hosts to the society and its auxiliary. Following dinner, Mr. Thomas Doran of the State Society office spoke on "The Problem of the Aged in Its Relation to Medical Care." The meeting then adjourned to the Arveson home for a social hour.

Price–Taylor

A regular meeting of the Price–Taylor County Medical Society was held in Medford on November 15. Following dinner at Mary and Pete's Club, the group adjourned to the city hall where a scientific program was presented. *Drs. R. S. Baldwin and P. F. Doege* of Marshfield were guest speakers for the occasion.

Richland

Dr. W. C. Edwards was named president of the Richland County Medical Society at the December 2 meeting at the hospital in Richland Center. *Dr. R. E. Housner* was elected vice-president and *Dr. L. M. Pippin* was re-elected secretary-treasurer. The new delegate is Doctor Housner and his alternate is *Dr. D. J. Taft*. All of the officers are from Richland Center.

Shawano

A Christmas dinner was given by the Shawano County Medical Society for its members on December 17 at the Shawano Municipal Hospital. During the business session, *Dr. R. R. Rivard* was elected president; *Dr. R. C. Cantwell* is the new vice-president; and *Dr. W. J. Schutz* is secretary-treasurer. All of the officers are from Shawano. Another feature of the meeting was a film on surgery.

Trempealeau–Jackson–Buffalo

Dr. G. I. Uhrich, La Crosse, was the guest speaker at the December 9 meeting in Independence of the Trempealeau–Jackson–Buffalo County Medical Society. The doctor chose "Analysis of 58 Gastrectomy Cases" as the subject of his talk. During the business portion of the meeting, *Dr. O. M. Schneider* of Blair took office as president, and the following officers were chosen for 1953:

President-Elect—*C. F. Meyer*, Mondovi
Secretary-Treasurer—*E. P. Rohde*, Galesville
Delegate—*Robert Krohn*, Black River Falls
Alternate—*F. C. Skemp*, Fountain City
Censor—*B. C. Dockendorff*, Arcadia

Walworth

Members of the Walworth County Medical Society and their wives attended a dinner meeting at the Colonial Hotel in Delavan on December 11. The annual election of officers was postponed because a number of the physicians were called from the meeting to attend patients.

Waupaca

New officers were elected by the members of the Waupaca County Medical Society at their December 11 meeting, held at the Marson Hotel in Clintonville. The president for 1953 is *Dr. J. H. Steiner* of Waupaca. Serving with him are *Dr. G. J. Hathaway*, King, as vice-president, and *Dr. W. R. McInnis*, Marion, as secretary-treasurer.

The guest speaker for the scientific part of the program was *Dr. J. J. Mulvaney*, Clintonville, who chose "Psychiatric Problems and Their Treatment in General Practice" as the subject of his talk.

Winnebago

Meeting on December 11 at the Hotel Athearn in Oshkosh, the Winnebago County Medical Society elected the following officers to serve for the ensuing year: president, *Dr. J. R. Nebel* of Menasha; vice-president, *Dr. Ben. S. Greenwood* of Oshkosh; and secretary-treasurer, *Dr. G. B. Hildebrand* of Menasha. *Dr. A. R. Curreri* of Madison was to have been the guest speaker for the occasion, but due to the bad weather he was unable to attend.

Wood

The members of the Wood County Medical Society met on November 13 at the Hotel Mead in Wisconsin Rapids. The meeting was primarily devoted to business and concerned chiefly a discussion pertaining to the fee schedule for the care of welfare patients.

News Items and Personals

F. A. C. S. Title Earned by Wisconsinites

A partial list of the Wisconsin surgeons who had been honored by a fellowship in the American College of Surgeons was published in the November issue of the Journal. Other Wisconsin surgeons receiving the F. A. C. S. distinction includes *Drs. R. F. Boock*, Beaver Dam; *F. J. Gallagher* and *M. T. O'Meara*, La Crosse; *J. T. Garren, Jr.* and *Louis Olsman*, Kenosha; *J. R. Hoon*, Sheboygan; and *K. H. Stahmer*, Wausau.

The Wisconsinites were among the more than 1,100 surgeons who were inducted as members of the College at the close of the September meeting of the organization which was held in New York City. A surgeon earns the designation F. A. C. S. by fulfilling specific requirements for acceptable medical education and advanced training as a specialist in one of the branches of surgery.

Air Force Honors M. D.

J. C. H. RUSSELL, M. D.

Dr. James C. H. Russell, Fort Atkinson physician and surgeon, was recently awarded the Commendation Ribbon for "exceptionally meritorious service" while serving as base surgeon with the 2473rd Air Force Reserve Combat Training Center at General Billy Mitchell Field, Milwaukee. Last September, Doctor Russell resumed private practice in Fort Atkinson after serving as a captain with the air corps since January of 1950.

Two New Physicians in La Crosse

Two new physicians started practice recently in La Crosse. They are *Dr. Robert E. McMahon*, internist, and Dr. James P. Pauly, gynecologist and obstetrician. The doctors have joined the staffs of the St. Francis Hospital and the La Crosse Clinic.

Doctor McMahon received his M. D. degree from the Columbia University College of Physicians and Surgeons and served his internship at St. Vincent Hospital, New York City. He spent two years in England while in the Army during World War II, and then took a residency in internal medicine at the University Hospital, Cleveland, Ohio.

Doctor Pauly is a graduate of the State University of Iowa College of Medicine and served his internship at the St. Francis Hospital, La Crosse, in 1944 and 1945. He completed a residency in his specialty at the University of Iowa Hospitals during the past year.

"I Hung Up My Shingle in Gleason"

When it became known that *Dr. W. H. Bayer* of Merrill was to receive his membership in the Fifty Year Club of the State Medical Society of Wisconsin at its 1952 Annual Meeting, the Merrill Daily Herald reprinted an article Doctor Bayer had written for the paper's centennial edition five years ago.

The paper stated "With the honors accorded in Milwaukee to . . . Dr. W. H. Bayer for his half century of service, it might be of interest to residents in this vicinity to read the story of his early pioneer days . . ." The story appeared under a banner headline, "I Hung Up My Shingle in Gleason 45 Years Ago."

Doctor Bayer's article tells of borrowing a bicycle to ride the 14 miles from Gleason to Merrill to register his license in the old County Court House. He recalls one occasion when he had to send a man on horseback to Wausau for antitoxin to combat a sudden outbreak of diphtheria in a lumber camp. He moved from Gleason to Merrill in 1920.

His article concludes with the following paragraph:

"Notwithstanding the hazards, hardships and difficulties of those early days, they were largely compensated for by the attainments achieved; by the many friendships made and by the pleasant memories held; so I do not regret that "I Hung Up My Shingle In Gleason."

Doctor Heiser Opens Office

Dr. P. Arthur Heiser, a native of Hamilton, Ohio, recently established a practice in general medicine in Woodville. The doctor is a 1951 graduate of Northwestern Medical School, Chicago, and served his internship at the Evanston (Ill.) Hospital.

Kenosha Has New Health Officer

Dr. Elmer E. Bertolaet has been named director of health for the City of Kenosha. He was formerly a health officer with the State Board of Health in District Two, with headquarters in Elkhorn. The doctor's appointment became effective on February 1. Kenosha had been without a health officer since July.

Hospital Staff Elects Officers

Dr. H. C. Schmallenberg of New London was elected president of the Community Hospital staff at a meeting held on December 9. *Dr. J. W. Monsted*, also of New London, is the retiring president. The other officers for the coming year are *Dr. L. F.*

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
(The Pioneer Post-Graduate Medical Institution in America, Organized 1881)

GENERAL and SPECIAL COURSES in MEDICINE, SURGERY, and ALLIED SUBJECTS

Urology

A combined full-time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cysto-endoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection; attendance at departmental and general conferences.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

Western Electric
HEARING AID

Air and Bone Conduction

There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.

Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE

AUDIPHONE UTILITIES

Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

DOERFLINGER ARTIFICIAL LIMB CO.

Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

Your Visit to Milwaukee

Is Made More Enjoyable by
Stopping at the SCHROEDER

Metropolitan atmosphere
Cocktail Lounge
Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses - 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting February 2, February 16, March 2
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2
Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16
Basic Principles in General Surgery, Two Weeks, starting March 30
Gallbladder Surgery, Ten Hours, starting April 20
Surgery of Colon & Rectum, One Week, starting March 2
General Surgery, One Week, starting February 9
General Surgery, Two Weeks, starting April 20
Fractures & Traumatic Surgery, Two Weeks, starting March 2
GYNECOLOGY—Intensive Course, Two Weeks, starting February 16
Vaginal Approach to Pelvic Surgery, One Week, starting March 2
OBSTETRICS—Intensive Course, Two Weeks, starting March 2
PEDIATRICS—Intensive Course, Two Weeks, starting April 6
Congenital Heart Disease, Two Weeks, starting May 18
MEDICINE—Intensive General Course, Two Weeks, starting May 4
Electrocardiography & Heart Disease, Two Weeks, starting March 16
Allergy, One Month and Six Months, by appointment
UROLOGY—Intensive Course, Two Weeks, starting April 13
Ten-Day Practical Course in Cystoscopy starting every two weeks
DERMATOLOGY—Intensive Course, Two Weeks, starting May 11

Teaching Faculty—Attending Staff of Cook County Hospital
Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

Morneau, vice-president, Bear Creek; and *Dr. G. M. LaCroix*, Shiocton, secretary-treasurer.

Doctor Bair Has New Associate

On December 1, Dr. Robert W. Cranston became associated with *Dr. G. W. Bair*, Platteville, in the practice of general medicine and surgery. A native of Minneapolis, Doctor Cranston received his medical degree from the University of Wisconsin Medical School in June 1949. He interned at the Evanston (Ill.) Hospital following his graduation. The doctor served with the Navy from 1944 to 1946 and again from 1950 to 1952 after the completion of his internship.

Doctor Tucker Addresses Kiwanians

Dr. W. J. Tucker, Ashland physician was the guest speaker at a recent meeting of the Ashland Kiwanians. His topic was coronary heart disease. The doctor began by listing ten rules for good health; he listed some of the symptoms indicative of heart disease; and, in conclusion, reviewed the progress that has been made in recent years in the treatment of heart disease and especially in surgery of the heart.

Doctor Zeiss to Head Hospital Staff

On December 11, *Dr. E. J. Zeiss*, Appleton, was elected president of the staff at St. Elizabeth Hospital. The election was held at a business meeting following the annual dinner which was served to 55 physicians and guests by Sister M. Patricia and members of her staff. Other officers named for 1953 are *Dr. A. E. Bachhuber*, Kaukauna, vice president; and *Dr. H. T. Gross*, Appleton, secretary-treasurer.

Doctor Ferguson Moves to Waupun

Dr. Edward C. Ferguson, formerly of Eau Claire, became associated with *Drs. J. P. Semmens* and *J. M. Sinnett* in the practice of medicine in Waupun on January 4. A 1951 graduate of Marquette University School of Medicine, Doctor Ferguson interned at the Little Company of Mary Hospital, Evergreen Park, Ill., and also did postgraduate work at the Chicago Maternity Center.

Doctor Sinnett was recently recalled to active duty with the United States Navy and is stationed at Pensacola Naval Air Station, Florida, where he is in the course of aviation medicine. Doctor Semmens also has been recalled for duty with the Navy. He will be senior medical officer stationed at Port Chicago, California.

New Officers Named by Lakeside Hospital

The staff of the Lakeside Methodist Hospital, Rice Lake, elected *Dr. D. G. MacMillan*, Rice Lake, chief of staff for 1953 at a meeting held on December 9. *Dr. C. J. Strang* was named vice chief of staff, and *Dr. J. R. Guy* was elected secretary. Both of the doctors are from Barron.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Kasten Honored by Interstate Group

H. E. KASTEN, M. D.

Dr. H. E. Kasten, Beloit urologist, was named president-elect of the North Central Conference of Medical Societies at a recent meeting of the conference held in Minneapolis. This group, which is made up of medical leaders from Wisconsin, Minnesota, Iowa, North and South Dakota and Nebraska, meets annually to discuss current medical problems affecting the midwestern states.

Dean Clinic Has New Staff Member

Dr. Arthur M. Sonneland, Cleveland, Ohio, has joined the staff of the Dean Clinic, where he will specialize in urological surgery. The doctor received his M. D. degree from Creighton University School of Medicine, Omaha, and interned at the Virginia Mason Hospital in Seattle. Following service with the Navy Medical Corps, he spent one year as a resident in surgery at St. Mary's Hospital. He then was located at the Cleveland Clinic in Cleveland as a fellow in urology.

Doctor Waters Enters Navy

Dr. Darwin D. Waters, Madison anesthesiologist, has been recalled to active duty with the Navy and has reported for assignment at the Great Lakes, Ill. Naval training station. A 1943 graduate of the University of Wisconsin Medical School, the doctor served in World War II wth the Navy and spent 15 months in the Pacific theater of war. He was recalled with the rank of lieutenant junior grade.

Wisconsin General Has New Assistant Superintendent

Dr. Ora McMurray, former West Allis physician, has been appointed assistant superintendent of the State of Wisconsin General Hospital. The doctor established his first private practice at Eagle River and later practiced at Greendale and West Allis. Early in 1950, he became a civilian doctor with the Army and was sent to Japan. He returned to this country in August.

Doctor Caldwell Joins University Staff

Dr. Marian Caldwell, a physician on the staff of the Badger Regional Blood Center, Madison, has

LIQUID PLASMA

U. S. LICENSE 187

Half pint units of liquid plasma available.
(Recipient set not included.)

Save by ordering directly from:

JUNIOR LEAGUE BLOOD CENTER

763 No. 18th St. Milwaukee 3, Wis.

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

ROEMERS—MILWAUKEE

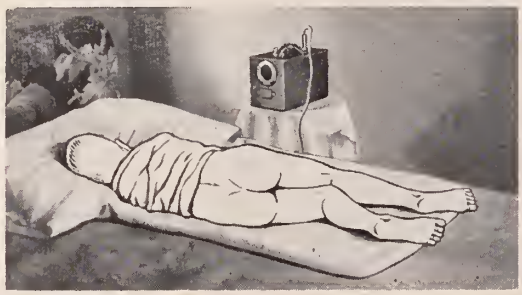
Surgical Supplies
Hospital Supplies
Office Furniture
Laboratory Supplies

* * *

Complete Service to the Medical Profession

* * *

Roemer Drug Company
606 No. Broadway
Milwaukee 2, Wisconsin



NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY
525 Holly Avenue, Madison 5, Wisconsin

resigned to accept the post of assistant physician of student health at the University of Wisconsin. Doctor Caldwell received her degree in medicine from the University in 1950 and interned at the Lutheran Hospital, La Crosse.

Doctor Gilbertsen Heads Staff

Dr. C. R. Gilbertsen, Janesville physician, has been elected president of the Mercy Hospital staff for 1953. A past-president of the Rock County Medical Society, Doctor Gilbertsen is a veteran of World War II, having served 22 months with the Navy.

Madison Physician's Book Published

Dr. Leslie Osborn, professor of psychiatry at the University of Wisconsin, is the author of a recently published book entitled "Psychiatry and Medicine." Written in non-technical language for medical students, the book will also interest physicians, nurses, psychologists, social workers, and others dealing with human problems. In addition to his teaching duties, the doctor is director of the Wisconsin Psychiatric Institute and the division of mental hygiene of the Wisconsin State Department of Public Welfare. He came to Wisconsin in 1950 from Buffalo, N. Y., where he had been head of the department of psychiatry at the University of Buffalo.

Doctor Reese Addresses New York Meeting

H. H. REESE, M. D.

Dr. Hans H. Reese, professor of neuropsychiatry at the University of Wisconsin, was one of the principal speakers at the semi-annual medical meeting of the National Multiple Sclerosis Society, held in New York City on December 11. Chairman of the society's medical advisory board, Doctor Reese restated the society policy of activating research projects centering around many divergent theories on the cause and control of multiple sclerosis.

Madison General Re-Elects Doctor Hill

Dr. N. A. Hill, one of the councilors of the Third District, was re-elected chief of staff of Madison General Hospital at a staff meeting held at the hospital on December 30. Other officers named were *Dr. T. A. Leonard*, vice chief of staff; *Dr. E. J. Nordby*, secretary-treasurer; *Dr. J. P. Malec*, chief of surgery; and *Dr. T. J. Nereim*, chief of the section of general practitioners. *Dr. Lester McGary* announced at the meeting that the hospital had been approved recently for a four-year residency in pathology.

Doctor Ewell Elected to AMA Committee

Dr. George H. Ewell, Madison, was one of 23 physicians elected to assist the Committee on Scientific Exhibit of the American Medical Association in selecting scientific exhibits for the association's annual meeting which is to be held in New York, June 1–5, 1953. The duties of committee members are to contact physicians regarding the presentation of an exhibit, and then to judge applications that are submitted to the committee.

Doctor Pranke Recalled to Navy Duty

Dr. D. W. Pranke, Beloit urologist and surgeon for the past year and a half, has been recalled to active duty with the Navy. He reported to the naval base at Norfolk, Va., on November 3. Doctor Pranke received his medical degree from the University of Illinois College of Medicine in 1944. He did additional study at the Research and Education Hospital at the University of Illinois and then served a two year residency in urology at the Veterans Administration Hospital, Hines, Ill.

Sauk

Meeting at the Warren Hotel in Baraboo on December 9, the Sauk County Medical Society held its annual election of officers. *Dr. C. R. Pearson*, Baraboo, was named president for the coming year, and the following physicians were elected to serve with him: *Dr. O. V. Pawlisch*, Reedsburg, vice-president; *Dr. J. J. Rouse*, Reedsburg, secretary; *Dr. J. F. Moon*, Baraboo, delegate; and Doctor Rouse, alternate. Serving on the board of censors are *Drs. J. A. Booher*, Reedsburg, *F. E. Tryon* and *K. D. L. Hannan*, both of Baraboo.

The guest speaker for the scientific portion of the meeting was Dr. A. B. Weinstein, Madison, who chose "The Treatment of Rheumatic Fever" as the title of his talk.

Hand Surgeons Meet at Columbia Hospital

About 60 specialists in hand surgery from the United States and Canada attended the opening session of the national convention of the American Society for Surgery of the Hand which opened at the Columbia Hospital in Milwaukee on January 22. Further sessions of the convention were held on January 23 and 24 in Chicago. Wisconsin physicians who presented papers at the meeting include *Drs. E. C. Welsh, W. H. Frackelton, J. P. Docktor, J. L. Garvey, David Cleveland* and *J. W. Temple.*

Three Physicians Appear on Television

Drs. Allan Filek of the State Board of Health, Madison, *John S. Hirschboeck*, dean of Marquette University School of Medicine, and *Edwin B. Gute* of Milwaukee appeared on WTMJ–TV at Milwaukee on January 4. They discussed the consolidation of public health facilities in Milwaukee County. The program was telecast as a "Wisconsin Forum."

RADIUM and RADIUM D+E
(Including Radium Applicators)
FOR ALL MEDICAL PURPOSES
Est. 1919
Quincy X-Ray and Radium Laboratories
(Owned and Directed by a Physician–Radiologist)
HAROLD SWANBERG, B. S., M. D., Director
W. C. U. Building Quincy, Illinois

To Serve Your Complete Prosthetic & Orthopedic Appliance Needs
HOUSE OF BIDWELL, INC.
MILWAUKEE, WIS. 604 N. Water St. R. G. Bidwell Phone: BR 2–1016
MADISON, WIS. 520 S. Park St. R. N. Bidwell Phone: 6–5303

HURLEY X-RAY COMPANY
Distributors for:
Picker X-Ray Corporation
Equipment—Supplies—Accessories
Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment
Ille Electric Corporation
Whirlpool—Paraffin Baths
Eastman—DuPont—Ansco
Films—Chemicals—Screens
For your requirements call or write
HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures "*know-how*"

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Daly 8-1021

In very special cases
A very superior Brandy

Specify 84 PROOF
★ ★ ★
HENNESSY
THE WORLD'S PREFERRED
COGNAC BRANDY
For a beautifully illustrated book on the story of Hennessy, write—
Schieffelin & Co., Dept. HT, 30 Cooper Square, N.Y. 54

Physician Receives Board Certification

Dr. Hans Hartenstein, a native Milwaukeean, was able to fly from the Ryukyus Islands, Okinawa, where he is stationed on active duty with the Army Medical Corps, to San Francisco for the purpose of taking the American Board of Pediatrics Examination. The examinations were held on June 28 and Doctor Hartenstein recently received official notice that he had successfully completed the tests. A 1947 graduate of the University of Wisconsin Medical School, the doctor interned at Mount Sinai Hospital, Chicago, and served pediatric residencies at Cook County Hospital, Chicago, and at the State of Wisconsin General Hospital, Madison.

Doctor Hankwitz Shows Movies

"Cruising Lake Michigan and a Bermuda Holiday" was the title *Dr. A. W. Hankwitz,* Milwaukee, chose for his Kodachrome movies which he presented on November 19 at the Milwaukee Public Museum. Doctor Hankwitz's presentation was a part of the Museum's regularly scheduled lecture program.

Pictured above at the December 11 meeting of the Medical Society of Milwaukee County are (from left to right) Drs. Robert S. Irwin, James G. Garland, Norbert J. Wegmann, and H. Kent Tenney.

Milwaukee

Meeting at the Athletic Club on November 13, members of the Medical Society of Milwaukee County heard an address by Dr. G. M. Meade, medical director of the Trudeau (N. Y.) Sanatorium. Doctor Meade reported on the sanatorium's use of the isonicotinic acid hydrazide drugs on 44 patients with far advanced tuberculosis.

When the society met on December 11 for its annual dinner meeting, *Dr. H. Kent Tenney* of Madison, president-elect of the State Society, was the guest speaker. During the business session, *Dr. Robert S. Irwin* was installed as president for 1953 and the following physicians were elected to serve with him: *Dr. James G. Garland,* president-elect; *Dr. Alice D. Watts,* secretary; and *Dr. Robert D. O'Connor,* treasurer. *Dr. N. J. Wegmann,* retiring president, was elected to the board of directors.

Milwaukee Academy of Medicine

"Differential Diagnostic Problems in Infectious Mononucleosis" was the title of an address by Dr. Israel Davidsohn of Chicago at the December 16 meeting of the Milwaukee Academy of Medicine. Doctor Davidsohn is professor of pathology at the University of Chicago School of Medicine. While in Milwaukee, the doctor also took part in a symposium on infectious mononucleosis which was held by the Marquette University School of Medicine Hematology Seminar Group.

The annual dinner meeting of the academy was held on January 20 at the University Club. *Dr. A. C. Schmidt* was installed as president and the annual election resulted in the following slate of officers: *Dr. A. A. Holbrook*, president-elect; *Dr. V. F. Lang*, vice-president; *Dr. J. F. Kuzma*, secretary; *Dr. Maurice Hardgrove*, treasurer; and *Dr. H. J. Lee*, library chairman.

The prizes for the two essay contests sponsored annually by the academy were presented at the January meeting to *Dr. E. C. Welsh* and Dr. J. P. Looze. The guest speaker for this meeting was Dr. E. V. Allen, senior consultant in the section of medicine at the Mayo Clinic. The title of his talk was "Apples Don't Fall Far From the Tree."

Milwaukee Neuro-Psychiatric Society

Meeting at the Milwaukee Sanitarium on January 21, the members of the Milwaukee Neuro-Psychiatric Society heard an address by Dr. John G. Dewan of Toronto, Canada. The doctor, who is associate professor of psychiatry at the University of Toronto, chose "Metabolic Investigations Relating to Schizophrenia" as the subject of his talk.

MARRIAGE

Dr. C. P. Haseltine, Oshkosh, to Miss Jane Elizabeth Brooks, Green Lake, on November 15.

SOCIETY RECORDS

New Members

E. F. Daley, 605 Minahan Building, Green Bay.

R. N. Worobec,* U. S. Army Hospital, Fort Belvoir, Virginia.

C. O. Lindberg, Grantsburg.

L. R. Pfeiffer, Cumberland Clinic, Cumberland.

T. F. Heighway, 2009 Mayflower Drive, Middleton.

R. P. Froeschle, Sparta Clinic, Sparta.

J. E. Nilles, 1416 18th Street, Two Rivers.

J. J. Brook, Jr., Marshfield Clinic, Marshfield.

G. E. Magnin, Marshfield Clinic, Marshfield.

J. C. Murphy, Middle River Sanatorium, Hawthorne.

R. J. Gardner, Menomonie Clinic, Menomonie.

J. P. Docktor, 324 East Wisconsin Avenue, Milwaukee.

A. P. Vrabec, 302 North Spring Street, Beaver Dam.

Changes in Address

John Huston, Jr., Madison to 2825 North Marietta, Milwaukee.

K. G. Kastl, Bala-Cynwyd, Pennsylvania to 1516 Kanawaha Boulevard, East, Charleston 1, West Virginia.

J. J. Haugh,* Milwaukee to AO2240789, 508th Medical Group, S.A.C., Turner Air Force Base, Albany, Georgia.

T. G. Malloy, Little Rock, Arkansas to 1803 North 57th Street, Milwaukee.

R. P. Still, La Grange Park, Illinois to 326 South Third Street, De Kalb, Illinois.

W. E. Archer, Madison to Box 511, Anoka, Minnesota.

K. K. Kaufman, Wood to 238 West Wisconsin Avenue, Milwaukee.

J. R. Mott, Urbana, Illinois to 146 East Wisconsin Avenue, Oconomowoc.

A. J. Kukral, Salt Lake City, Utah to 2660 South Lincoln Street, Denver, Colorado.

C. P. Giesen, Milwaukee to 8500 West North Avenue, Wauwatosa.

J. Gurney Taylor, Milwaukee to 4379 Ingraham Highway, Miami, Florida.

R. R. Redlin,* Milwaukee to Naval Hospital, Corona, California.

F. J. Pulito,* Milwaukee to 3259 55th Street, San Diego, California.

J. S. Barnes, Milwaukee to 218 15th S. W., Albuquerque, New Mexico.

Jonathan Slomowitz,* Milwaukee to Great Lakes Naval Center, Great Lakes, Illinois.

A. M. MacKay, San Carlos, California to 221 Topaz Street, Redwood City, California.

Tokuso Taniguchi,* Camp Pickett, Virginia to Fort Lawton Personnel Center, Seattle, Washington.

R. F. Scheller,* Milwaukee to 1330 Fulton Avenue, San Antonio, Texas.

H. C. Dangle, Wood to Waukesha Memorial Hospital, Waukesha.

H. E. Oppert, Madison to 318 South Main Street, Viroqua.

L. W. Keller,* Fort Sam Houston, Texas to 02097327, Med. Det., 2nd Bn., 4th Inf., A.P.O. 937, % Postmaster, Seattle, Washington.

H. O. Caswell, Fort Atkinson to Jefferson County Hospital, Jefferson.

W. J. Little, Statesan to 624 Augusta Street, Racine.

L. W. Eidam, La Crosse to 1722 Prospect Avenue, Santa Barbara, California.

J. S. Feurig, Columbia, Missouri to Olin Memorial Health Center, East Lansing, Michigan.

D. J. Price, South Milwaukee to 2205 South 30th Street, Milwaukee.

W. C. Webb, Maxwell Air Force Base, Alabama to V.A. Hospital, Wood.

E. C. Ferguson, Eau Claire to 315 East Main Street, Waupun.

E. E. Bertolaet, Elkhorn to City Health Director, Kenosha.

PORTABLE OXYGEN . . .

constantly at your service

You now can have oxygen available whenever you need it for medical emergencies in your office or on calls. A portable "Q" cylinder of "Linde" Oxygen U.S.P. plus a clinical regulator and mask will help you cope with anoxia without delay.

A "Q" cylinder contains enough oxygen for about five hours use. Keep a "Q" and a regulator in your office; take it along on calls for emergency use.

available from any of these distributors of

Linde OXYGEN U.S.P.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding Supply Div. of Northern Auto Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS LITER FLOW ADAPTORS • OXYGEN THERAPY ADMINISTERING EQUIPMENT

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

W. J. Kelly, Potosi to 1959 Stanton Street, Dubuque, Iowa.

S. T. Gettelman, Fort Riley, Kansas to 1036 Grove Avenue, Racine.

D. A. Cofrin,* Green Bay to 811 West Elm Avenue, Enid, Oklahoma.

H. S. Ashe,* Mercer to 1213 Wisteria Road, Aero Vista, Pensacola, Florida.

H. E. Schaefer,* Randolph Air Force Base, Texas to AO2240773, 3560 Medical Group, Webb Air Force Base, Big Spring, Texas.

J. W. Connell, Fond du Lac to V.A. Hospital, 200 Veterans Avenue, Beckley, West Virginia.

W. G. Dixon, La Crosse to State Psychopathic Hospital, Iowa City, Iowa.

J. J. McLeod, Jr., Great Lakes, Illinois to 425 21st Avenue East, Superior.

* Military Service.

DEATHS

Dr. George J. Fiebiger, Waterloo physician for 53 years, died on November 15 at a Watertown hospital. He was 78 years old.

A native of Jefferson, the doctor received his medical degree from Northwestern University Medical School and served a year's internship at the Grant Hospital in Chicago. In 1911 he returned to medical school for a year to take postgraduate work in eye, ear, and nose diseases.

Last September the communities of Waterloo and Marshall held a testimonial banquet in honor of the doctor's more than 50 years of service to the community.

He is survived by two sisters and two brothers.

Dr. Simpson M. Markson, chief of staff of the Milwaukee County General Hospital in 1941, died suddenly on November 17 at his home in Milwaukee. He was 69 years old.

Born in Glen Robertson, Ontario, Canada, on January 14, 1883, he earned the degrees of Doctor of Medicine and Master of Surgery from McGill University Faculty of Medicine, Montreal, Quebec, and first practiced medicine in what is now the State of Oklahoma. He established his practice in Milwaukee in 1907 and later did postgraduate work in Chicago and in Vienna, Austria.

Doctor Markson was professor emeritus of the Marquette University School of Medicine, where he had served on the faculty from 1920 until 1951. At the time of his retirement he was director of the department of dermatology.

In addition to serving as chief of staff of Milwaukee County General Hospital, the doctor was also on the staff of Mount Sinai, Children's and St. Joseph's hospitals. He was a member of the American Academy of Dermatology and Syphilology, the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State

Medical Society, and the American Medical Association.

He is survived by his wife and a son, Dr. Leonard S. Markson.

Dr. George W. Walter, Racine physician for the past 22 years, died on November 22 at his home in Racine. He was 50 years old.

A native of Oshkosh, the doctor was born on February 22, 1902. He was a graduate of Northwestern University Medical School and interned at Passavant Hospital, Chicago, and at the Evanston (Ill.) Hospital. He completed his postgraduate training at Lying-in-Hospital, Chicago, and at Children's Hospital in St. Louis.

Doctor Walter was especially active in traffic safety work and was national vice president of the American Automobile Association, as well as director of the Racine County Safety Council. He was a past president of the Racine County Medical Society, and was also a member of the State Medical Society and the American Medical Association.

Survivors include his wife, a son, and a daughter.

Dr. Robert W. Burns, 48, medical director of Hickory Grove Sanatorium and a practicing physician in Green Bay, died suddenly on December 1 at his home. He was born in Green Bay on November 27, 1904.

A 1930 graduate of Marquette University School of Medicine, Doctor Burns interned at St. Elizabeth Hospital, Youngstown, Ohio; held a residency at Johnston Emergency Hospital, Milwaukee; and did postgraduate work at the Lying-in-Hospital in New York City before returning to Green Bay to establish his practice.

The doctor was a past president of the Brown–Kewaunee–Door County Medical Society, and was also a member of the American Trudeau Society, the Wisconsin Anti-Tuberculosis Association, the American Academy of General Practice, the State Medical Society, and the American Medical Association.

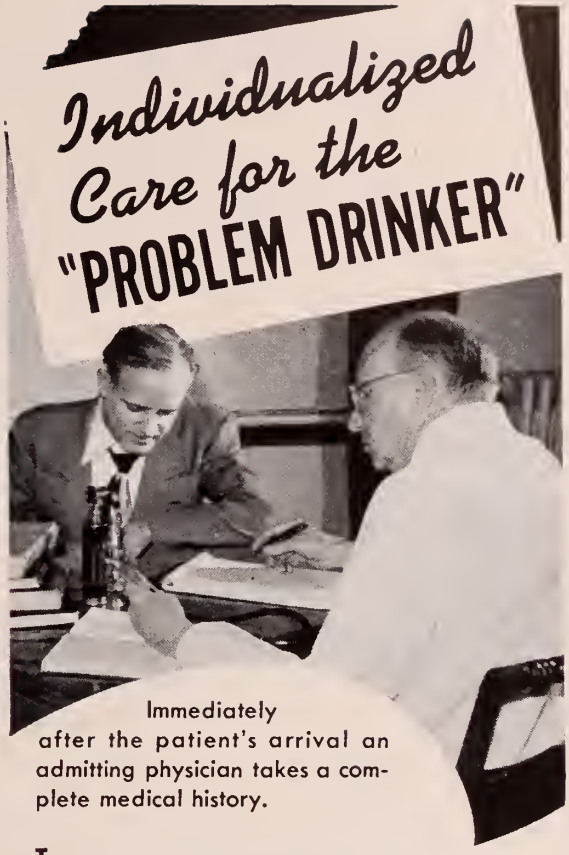
Surviving him are his wife, a son, and a daughter.

Dr. James J. Fitzgerald, 82, physician in the village of Eagle for the past 57 years, died on December 9 in a Milwaukee hospital. He was born in Oconomowoc on February 25, 1870.

The doctor's first career was teaching. He later decided to become a physician and was graduated from Rush Medical College, Chicago. He began his practice in Eagle in 1895.

Doctor Fitzgerald found time to participate in many civic activities of his community, including serving as a member of the school board, as director of the Eagle Bank and as vice-president of the Eagle Telephone Company. He was a member of the Fifty Year Club of the State Medical Society, and was also a member of the Waukesha County Medical Society and the American Medical Association.

Survivors include his wife and two sisters.



Immediately after the patient's arrival an admitting physician takes a complete medical history.

Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Dr. Harris J. Irwin, 92, retired Baraboo physician, died December 29 in a Madison hospital. He had practiced in Baraboo for 53 years prior to his retirement in 1948.

Born in Lodi on January 22, 1860, the doctor was one of seven physicians in the Irwin family. He attended the University of Wisconsin and later received his medical degree from the University of Louisville School of Medicine. He practiced in Lodi for one year prior to moving to Baraboo.

Doctor Irwin had served as president of the Sauk County Medical Society for several different terms, he was a member of the Fifty Year Club of the State Medical Society, and was a member of the American Medical Association. In 1913 he was made a life member of the Surgeons' Club of Rochester, Minn.

He is survived by his wife.

Dr. David S. Runnels, 81, a retired Appleton physician, died on December 29 at his home. He was born in Red Oak, Iowa on May 3, 1871.

A 1900 graduate of the Chicago Homeopathic Medical College, the doctor's first practice was established in Merrill. In 1910 he moved to Appleton where he was active until his retirement in 1942.

He is survived by his wife and two sisters.

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2611 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.

PHYSICIAN AND HOSPITAL SUPPLIES

FOUR STORES

Complete Stocks Of Medical Specialties

Orders Filled Promptly

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 Milwaukee, Wis.

Distributors to the profession

of fine

Injectable Vitamins and Endocrines

Interstate Pharmacal Company

P. O. Box 252 Beloit, Wis.

MAIL ORDERS SHIPPED IMMEDIATELY

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin

1953 CLINIC

Reservation

Fee: $6 each clinic
(Including Dinner)

[CHECK CLINICS YOU WILL ATTEND]

MAR. 24 (Tues.): Beaver Dam ☐
MAR. 25 (Wed.): Marshfield ☐
MAR. 26 (Thurs.): Neenah ☐

APR. 14 (Tues.): West Bend ☐
APR. 15 (Wed.): Shawano ☐
APR. 16 (Thurs.): Stevens Point ☐

MAY 13 (Wed.): Delavan ☐
MAY 14 (Thurs.): Sheboygan ☐
MAY 15 (Fri.): Green Bay ☐

June Clinics:

Wives Invited!
Special Joint Program

JUNE 24 (Wed.): Resort: Hayward ☐
JUNE 25 (Thurs.): Resort: Minocqua ☐

NAME _____
STREET _____
CITY _____

Make check payable to:
STATE MEDICAL SOCIETY
OF WISCONSIN

Mail to: Box 1109, Madison, Wis.

THE MARY POGUE SCHOOL

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

Catalogue on request.

G. H. MARQUARDT, M. D.
Medical Director

BARCLAY J. MACGREGOR
Registrar

32 Geneva Road, Wheaton, Ill. (Near Chicago)

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

AVAILABLE FOR YOUNG PHYSICIAN: Office space and equipment for general practitioner. Excellent location in business-residential section of Madison. Will arrange lease and ultimate purchase of equipment, if so desired. Write box 460 in care of the Journal to arrange for interview and inspection of office.

FOR SALE: Complete office equipment and library of deceased physician. For further information write to box 472 in care of the Journal.

FOR RENT: Desirable office space, consisting of 2 large treatment rooms, spacious furnished waiting room. Will share lab. Air conditioned building in new heavily populated area. Partly occupied by general physician and dentist. Write Maurice Olsen, M.D., 7623 W. Burleigh, Milwaukee 10, Wis.

WANTED: Bright experienced girl for all around work in general physician's office. Experienced in bookkeeping, typing, and receptionist work. Another girl employed. Must be willing to work 2 or 3 evenings a week. Write Maurice Olsen, M.D., 7623 W. Burleigh, Milwaukee 10, Wis.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE by retired physician, Fischer diathermy machine, Miller short wave machine, and McIntosh polysine generator. Best offer accepted. Write or call Dr. E. M. Rice, 1738 Alta Vista Ave., Wauwatosa 13, Wis. Phone Bl. 8-2300.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

PHYSICIAN WANTED as an associate for a well established practice including surgery in a college and industrial city of about 6,000 in the Fox River Valley. Fully equipped and newly remodeled ground floor office of 12 rooms. Staff appointment open in 50 bed hospital. Salary, percentage, or private enterprise basis. Present M.D. owner unable to carry on practice alone due to health. Address replies to box 464 in care of the Journal.

RADIUM FOR SALE: One 50 mg. and thirteen 10 mg. cells with variety of capsules and application instruments, at 10 per cent below market price of radium. Also divided. Address replies to box 465 in care of the Journal.

FOR SALE: Active general practice and equipment in modern office building in Manitowoc. Owner is Priority II and has been drafted. Outright sale, rent, or partnership considered. Address replies to box 466 in care of the Journal.

GENERAL SURGEON, four years training, large general hospital, age 33, desires association with general surgeon, group, or clinic. Call Milwaukee Spring 4-9314 or write box 467 in care of the Journal.

WANTED, oto-laryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

PHYSICIANS, with or without public health training, and pediatricians needed in maternal and child health program at salaries from $6,908 to $9,887. Five day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, City Hall, Milwaukee, Wis.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2-8118.

FOR SALE: Resectoscope, never used. A.C.M.I. 28 French, complete with box, cords, lights, 2 sheaths, resecting unit, and extra cutting tips, etc. Address replies to box 469 in care of the Journal.

FOR SALE: One 30 MA-90 KV Westinghouse X-Ray mobile unit, bucky table and other complete accessories. Office equipment including scale, exam table, surgical instruments and cabinet, short wave diathermy machine and B. D. Manometer. Write to Mrs. Viola Berg, Gillett, Wisconsin.

FOR SALE: Building built to be combination home and doctor's clinic. Three years old and located in Cambridge, which is 22 miles east of Madison and 58 miles west of Milwaukee. Opportunity for large practice available. Building is very modern and offered at a sacrificed price, terms to suit buyer. For further information write or call A. M. Wheeler, 536 W. Wisconsin Ave., Milwaukee. Phone Br 1-6772.

WANTED: Used hospital size Bovie Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5-9100.

FOR SALE: Two metal, chrome and white, treatment chairs and stools. Adjustable backs, head rests, seats, and arms. Write Mrs. W. F. Krueger, 2473 N. 84th St., Wauwatosa, Wis., or call Greenfield 6-3517.

FOR SALE: Complete eye, ear, nose, and throat equipment, including all surgical, diagnostic, and refracting instruments. Make an offer for quick sale. Address replies to Mrs. D. G. Hugo, 508 Washington Blvd., Oshkosh, Wis.

FOR SALE: Practice of the late Dr. J. J. Fitzgerald, Eagle, Wis. Beautiful modern home, office in residency with separate entrance. No competition. Physician badly needed. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

WANTED: Physician as an associate in general practice, preferably with surgical training and service exempt. City of 10,000 population in north central Wisconsin, with excellent hospital facilities and on a salary basis with eventual partnership. Address replies to box 473 in care of the Journal.

FOR SALE: Optometric equipment in good location for a physician who does refraction. Equipment valued at $600. Address replies to box 474 in care of the Journal.

WANTED: Pediatrician, or general practitioner willing to do large share of pediatrics, in an active group practice in suburban Milwaukee. Address replies to box 475 in care of the Journal.

GENERAL PRACTITIONER, middle-aged with extensive experience, desires association or location. Available about June 1, 1953. Address replies to box 476 in care of the Journal.

PHYSICIAN WANTED, preferably one with one or two years experience in private practice, as an associate in a well established general and surgical practice in a city of over 30,000. Address replies to box 478 in care of the Journal.

GENERAL SURGEON WANTED by group of four young men with training in internal medicine, obstetrics and gynecology. Newly established group with offices 17 miles east of St. Paul, Minn. Excellent future. New 35 bed fully equipped hospital. Address replies to box 479 in care of the Journal.

E.E.N.T. PRACTICE FOR SALE: Twenty year location, income considered very large, and collections 96 per cent. Cultural, social activities, and schools are very fine. Price $8,000, divided over period of three years. Population 15,000, suburbs 6,000, and drawing around 50,000. Sports include skiing, muskies, golf, and hunting. Optional purchase may include $50,000 four bedroom, three bath, beautiful home for $25,000. Address replies to box 480 in care of the Journal.

LOCATION WANTED: General practitioner, age 28, married, family, desires assistantship, association, or location. Completing 24 months active duty in Army on April 1. Licensed in Wisconsin. Graduate of U. of Wisconsin Medical School. Has own office furniture and equipment. Address replies to box 481 in care of the Journal.

535 North Dearborn Street, Chicago 10, Illinois

AMERICAN MEDICAL ASSOCIATION news notes FEBRUARY, 1953

AMA news written especially for use in state medical journals

AMA Revises the "Essentials of an Approved Internship"

An Advisory Committee on Internship, appointed by the Council on Medical Education and Hospitals in the fall of 1951, conducted a study in the past year reviewing the internship in its broadest aspects. As a result of its study the Advisory Committee recommended revisions in the "Essentials of an Approved Internship" which were ratified by the AMA's House of Delegates in December.

Among the changes in the requirements for hospitals offering intern programs were the following: Approval by the Joint Commission on Accreditation of Hospitals; bed capacity increased to 150, excluding bassinets; annual admissions increased to 5,000, exclusive of the newborn, and the autopsy rate increased to 25 per cent.

Under these revisions the Council will approve rotating and mixed internships and straight internships in these specialties—internal medicine, pediatrics and surgery. Straight internships in pathology and obstetrics-gynecology will no longer be approved.

The revised "Essentials" became effective January 1 for new approvals. The autopsy rate of 25 per cent became effective for all hospitals January 1.

AMEF '52 Funds Total More Than $886,430

Contributions to the American Medical Education Foundation in 1952 totaled more than $886,430. This includes an American Medical Association grant of $500,000 voted by the House of Delegates in December, 1951, at Los Angeles. In all, 6,739 contributions have been recorded from 6,697 individuals, 11 laymen and 31 organizations.

Distribution of Class A grants for the 79 medical schools in the country was made in August . . . $15,000 for each of the 72 four-year schools; $7,500 for each of the six two-year schools, and $11,250 for one three-year school.

Particularly encouraging . . . contributors up 4,863 over 1951 . . . total receipts up $140,513 over 1951.

Two Big Farm Groups Show Interest in Health

Two big farm organizations—the American Farm Bureau Federation and the National Milk Producers Federation—held their annual meetings last month, and both adopted resolutions pertaining to rural health.

Representatives of the A. M. A. Council on Rural Health attended both sessions.

The American Farm Bureau Federation, which claims a membership of a million-and-a-half families, met in Seattle and adopted a resolution, which read in part:

"The interest of rural people in better health is increasing . . . Where needed, state and local communities can and should further expand their programs; however, economic factors must be given consideration in determining additional hospital needs. Training of qualified persons can be expanded. Local or private educational scholarships or loans will aid . . . Rural people can cooperate in furnishing medical offices and centers with equipment and other facilities. Education of the public on health and sanitary measures and the care and facilities available will improve rural health conditions . . .

"Greater emphasis should be placed upon preventive medicine . . . We will continue to cooperate with other groups in providing better voluntary medical care for rural people. We encourage continued support of those meritorious voluntary programs which are established to deal with special health and disease problems . . . We favor voluntary plans providing medical, health, dental and hospital insurance . . . We urge a friendly attitude and fuller understanding on the part of the medical profession and hospitals toward private prepaid medical and hospital insurance plans and the principles of their operation . . . We oppose any form of compulsory health insurance."

The resolution adopted by the National Milk Producers Federation stated that "we are convinced that health programs in this country must in the last analysis depend upon individual and group responsibility rather than rely upon governmentally-conceived compulsory, socialistic programs."

New PR Booklet Is "AMAzing Story"

"AMAzing Story" is the title of a new public relations booklet put out by the AMA for the purpose of showing the public the diversity of the fields in which it labors for the welfare of physicians and the general public.

The story is told in twelve attractive pages with a minimum of copy and a maximum of illustration. It presents "Joe Typical" and his family and explains how the AMA enters into their lives indirectly by nutritional study, checking of drugs and cosmetics, testing of instruments and hospital equipment, and standardization of hospitals and medical schools. Other AMA services are briefly summarized.

The booklet may be obtained from the State Medical Society or from AMA offices in Chicago.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors -- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- F. J. Mellencamp, Milwaukee
Secretary ---------- E. H. Pawsat, Fond du Lac
Vice-chairman ------- N. L. Low, Racine
Delegate ---------- K. B. McDonough, Madison
Alternate ---------- K. J. Winters, Wauwatosa

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	8
American Meat Institute	13
Audiphone Utilities	35
Ayerst, McKenna & Harrison, Ltd.	20
Baker Laboratories	18
Barr X-Ray Company	45
Benson Optical Company	5
Bergmann Prescription Center	25
Central Drug	25
Coca Cola Company	31
Cook County Graduate School of Medicine	36
Doerflingers	35
Endocrine Laboratories	37
General Electric Co., X-Ray Department	17
Hotel Schroeder	36
House of Bidwell	39
Hurley X-Ray Company	39
Interstate Pharmacal Company	45
Ivanhoe Sanitarium	14
Junior League Blood Center	37
Keeley Institute	43
Kennedy–Mansfield	25
Lederle Laboratories	facing page 19
Lilly, Eli and Company	22
Linde Air Products	42
Mallard, Incorporated	12
Mallatt Pharmacy	25
Mather Pharmacy	25
Mayer Drug	25
Mead Johnson and Company	51
Medical Protective Company	40
Merck and Company	15
Milwaukee Sanitarium	52
New York Polyclinic	35
Nichols, John, Inc.	147
Orgo Products Company	4
Orthopedic Appliance Company	45
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	11
Physicians Casualty Association	14
Pogue, Mary, School	45
Professional Business Service	145
Quincy X-Ray & Radium Laboratories	39
Rennebohm's	25
Roemer Drug Company	38
Rogers Memorial Sanitarium	52
S. and L. Signal Company	38
Sacred Heart Sanitarium	44
St. Croixdale Sanitarium	5
Schering	7
Schieffelin and Company	40
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	35
Smith–Dorsey	16
Squibb, E. R. and Sons	6
Stanley, Inc.	44
Summit Hospital	31
Time Insurance Company	143
Upjohn Company	19
Wander Company	10
Winthrop–Stearns, Inc.	21
Wisconsin Life Insurance Company	4
Wyeth	9

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	H. W. Harris Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette-Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospita
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida-Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce-St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price-Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. E. Martineau Elkhart Lake	J. F. Hildebrand 1011 N. 8th Sheboygan	First Thursday
Trempealeau-Jackson-Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	R. S. Galgano Delevan	K. C. Bill Elkhorn	Second Thursday*
Washington-Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	E. E. Debus Wisconsin Rapids	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 MARCH, 1953 Number 3

Some New Points in Cochlear Anatomy and Their Physiologic Implications*

By A. C. HILDING, M. D., Ph. D.
Duluth, Minn.

THAT our knowledge concerning the internal ear is inadequate at this time is testified to by our lack of understanding of the physiology of hearing and the fact that deafness due to anatomic changes usually remains permanent. The etiology and pathology of some of the commonest ear complaints, such as tinnitus and nerve deafness of the elderly, are unknown. The mechanism producing acoustic trauma and the pathologic changes involved are unclear. On the whole, we have no cure for any internal ear pathology, but we may be able to accomplish something in the field of prevention.

Future progress, it seems to me, is dependent upon a better understanding of the anatomy, physiology, and pathology of the internal ear. A great many facts are already known about the internal ear but most of them seem to be largely disregarded in theories of hearing. A great deal of fine study has been lavished on the movements of the basilar membrane in response to sound vibration. The basilar membrane, as I understand it, is chiefly a supportive structure. The up and down movements of the basilar membrane and the structures upon it have been generally assumed to be the movements stimulating sound perception. The tectorial membrane, on the other hand, has been comparatively neglected, although it is usually admitted that the stimulation must occur between the hair cells and the tectorial membrane. The tectorial membrane is often pictured as floating free above the hair cells, attached only at its origin on the limbus. It is said that as the basilar membrane responds to sound vibration, the hair cells are made to rise and fall in such a manner that the hairs strike against the under surface of the tectorial membrane. This is supposed to result in a stimulus. It seems to me that such impingement would be impossible from the standpoint of physics because the tectorial membrane would also rise and fall with the same sound vibrations and contact would not be made.

Von Muralt, physiologist at the University of Bern, Switzerland, in his address on the physiology of hearing at the 1952 meeting of the Collegium Oto-Rhino-Laryngologicum in Zurich, stated that no theory of hearing advanced up to the present time is satisfactory. He feels that studies on models may be good exercises in physics but have no relation to hearing. He claims that when the correct theory of hearing is found, it will be based on simple principles. In formulating this theory all known anatomic facts, including the existence of a third, entirely closed canal, must be taken into account. Von Muralt strongly urged that we clean the slate and make an entirely fresh start in this sphere.

When I was invited to spend this last academic year at Columbia University doing research, principally on the ear, I determined to attempt to demonstrate the attachments of the tectorial membrane. This membrane, as just stated, is usually pictured with the outer margin entirely free, the main body floating up above the hair cells, and the only attachment at the origin upon the limbus.

Unless one is working constantly in this field, it is difficult to keep the intimate points of the anatomy of the cochlea clearly in mind. To review some of the salient anatomical features, we recall that the cochlea is a coiled, hollow, bony structure containing about two and a half turns and, in some respects, resembling a snail shell. In cross section, the bony cochlear spiral is roughly circular and is larger at the apex than at the base. This is true of many of the contained structures. Because the terminology of the anatomic structures of the cochlea is somewhat confusing, with both bony and membranous portions to be considered, I shall use descriptive terms.

This bony canal, which is circular in cross section, is divided into an upper and lower half by the basilar membrane and its attachments. (Fig. 1) The lower half is called the scala tympani. The

*Presented before the Section of Ophthalmology and Otolaryngology at the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952.

Research done as visiting research professor, Columbia University, Department of Otolaryngology, and supported in part by grants from the Research Council of the American Otological Society and by the Hayden–Coakley Memorial Fund.

upper half is subdivided by a membrane, placed roughly at an angle of 45 degrees, into the scala media and the scala vestibuli. The scala vestibuli and scala tympani can be likened to two parallel connecting ramps, the scala vestibuli beginning in the vestibular portion of the internal ear and spiraling upward for two and a half turns, then connecting with the scala tympani through a generous opening called the helicotrema. The helicotrema is found about a half or a third of a turn short of the apex and occupies an almost central position in the coil. From the helicotrema, the scala tympani proceeds downward for two and a half turns to the round window where it terminates and is separated from the middle ear by the thin round window membrane. The scala media is a closed canal and is part of the endolymphatic system; it does not open into the scala tympani nor the scala vestibuli. It lies between the basilar membrane, which is below, and Reissner's membrane, above, and the upper arm of the spiral ligament on the outer side. In cross section, it is wedgeshaped. (C in Fig. 1)

Fig. 1—Photomicrograph of a section through the cochlea. The basilar membrane divides the bony canal into two portions, the scala vestibuli (V) above and the scala tympani (T) below. The organ of Corti lies on the basilar membrane in the cochlear canal (C). L = ligamentum spiralis. S = lamina spiralis ossea.

The basilar membrane, which divides the cochlear bony spiral into the two halves, is attached on the inner side to a spiral bony shelf, called the lamina spiralis ossea. (Fig. 1) The outer margin has a unique attachment to the so-called spiral ligament, which, on cross section, resembles two intersecting crescents. Putting it another way, the spiral ligament, which covers the inner aspect of the outer half of the bony cochlear spiral, is pulled inward at about its midpoint in such a way as to form a tent. Corti's organ lies on the upper surface of the inner half of the basilar membrane but does not extend completely to the inner margin. To the inner side of the organ of Corti lies a semi-canal called the inner sulcus. In some respects the organ of Corti resembles the retina. It is an ensemble of cells containing and supporting the sense cells and the nerve fibers which serve the sense cells. The sense cells are called the hair cells and are divided into two groups by a triangular shaped canal called the tunnel. The inner group, a single line of sense cells, is termed the inner hair cells, while those on the outer side have been named the outer hair cells. Of the outer hair cells there are from three to five rows, the smallest number being in the base and the largest number in the apex. The sense cells are partially supported by Deiter's cells and partially by a fibrous arch, described by Held some 25 years ago and called by him the "stutzbogen." Lying upon the basilar membrane and leaning against the outer side of this fibrous arch, there is a mass of cells known as the cells of Hensen. On the inner side of the arch is a similar, smaller mass of cells—the border cells. The border cells, the fibrous arch, the tunnel, Deiter's cells, and the cells of Hensen altogether constitute the organ of Corti. The organ of Corti, like the basilar membrane upon which it rests, spirals through the full two and a half turns of the cochlea and, on cross section, forms half a circle. There are other cells lying upon the upper surface of the basilar membrane, outside of the organ of Corti, which are called the cells of Claudius.

There is another important structure, resting upon the inner portion of the basilar membrane adjacent to the lamina ossea, which is composed largely of vertically placed cells. On cross section, this structure is more or less wedge-shaped with the apex lying at the margin of the bony lamina. The base is concave and shaped in such a way as to form the inner wall of the inner sulcus. The upper free margin of the wedge forms a rather sharp edge from which the tectorial membrane originates, or, putting it another way, the tectorial membrane originates from the entire upper surface of the limbal wedge and sometimes also from the concave base.

The tectorial membrane is a gelatinous structure, shaped like a thick spiral ribbon. The inner margin originates from the limbus and the tectorial membrane is generally pictured as having no other attachment, although it is assumed that contact is made in some way between the tectorial membrane and the hair cells during stimulation by sound vibration. Many believe that the hair cells are attached to the tectorial membrane and a number of workers, among them Prentiss and Kishi, have stated that the outer margin is attached to the cells of Hensen. Shambaugh claimed that there was an attachment also at Hensen's stripe to the border cells of the inner sulcus. None of these has ever been satisfactorily demonstrated and their existence is not generally accepted.

The scala media, containing the organ of Corti, tectorial membrane and limbus, is roofed over by Reissner's membrane, a structure which, on cross section, appears very thin and resembles a straight line. In the base it forms an angle of about 45 degrees with the basilar membrane; as it proceeds up the spiral toward the apex, this angle increases until, at the tip of the apex, it reaches almost 90 degrees.

My primary objective was to determine the attachments of the tectorial membrane. Most of the workers studying the tectorial membrane during the last half century have used fixed histologic preparations, but I attempted to dissect the structures in situ in the fresh state without any fixation.

As a great many workers can testify, opening the cochlea by dissection without significantly altering the contained structures is an exceedingly difficult task because the bone is very hard and the structures within unusually fragile. I dissected about 130 specimens (100 human temporal bones) most of which were removed fresh at autopsy, performed as soon after death as possible.

From these studies it became apparent that the tectorial membrane is normally attached to the organ of Corti. (Fig. 2) The outer margin is inserted upon Hensen's cells by means of a very thin net or membrane. (Fig. 3) In the middle of the under surface, it is also inserted upon the border cells along Hensen's line. Between these two insertions the under surface is connected with or in contact with the hair cells in a zone which may be termed the contact zone. These attachments were not found in all of the specimens dissected, and only about one-tenth actually showed more or less intact insertions.

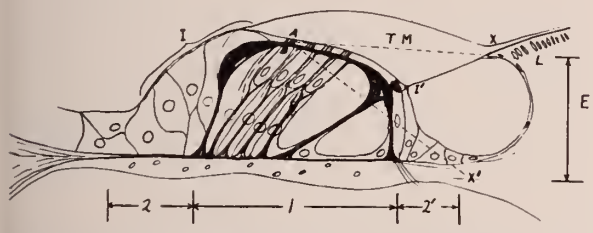


Fig. 2—Sketch of the organ of Corti in cross section with the more or less rigid arch ("stutzbogen") described by Held outlined in heavy lines (I). The mobile arch here described is outlined in thin lines and consists of Hensen's cells (2) and the border cells (2^1) and the tectorial membrane (T.M.) The outer margin of the tectorial membrane is inserted upon Hensen's cells at I and Hensen's stripe is inserted upon the border cells at I^1.

As these two arches move up and down, the center of rotation of the tectorial membrane is at X and that of the organ of Corti at X^1.

The insertion at the outer margin, which seems to be non-stretchable and non-yielding, is especially difficult to preserve during dissection. For reasons which will be brought out later, there is little tolerance (using machinist's terminology) and any excessive extension, i.e., depression, of the organ of Corti results in tearing of this insertion. Such overextension is difficult to avoid because, as the bony cap is removed, the upper arm of the spiral ligament is released from its origin, permitting the basilar membrane to sag, resulting in excessive strain upon the insertion at the outer margin.

With these attachments clearly in mind, it becomes obvious that there exists a second arch heretofore undescribed. (Fig. 2) This arch consists of three parts—the mass of Hensen's cells on the outside, the smaller mass of border cells on the inside, and the tectorial membrane, extending between these two cell masses and attached to both. In working with these cell masses, the border cells and Hensen's cells, one is impressed with the fact that they are highly mobile within a very limited range. The cells are large and individually are round but, when grouped together, are faceted like the cells in a honeycomb. They seem to yield readily within a short, fixed range when they are moved during microscopy. This would imply that the tectorial membrane, extending from one of these cell masses to the other and attached to both, would, therefore, also have a limited range of motion. This mobile arch fits closely over the stiff, non-yielding arch (Held's stutzbogen) in which the hair cells are fixed. From the standpoint of the physiology of hearing, I feel that the relationship of these two arches and the movement possible between them are of primary importance.

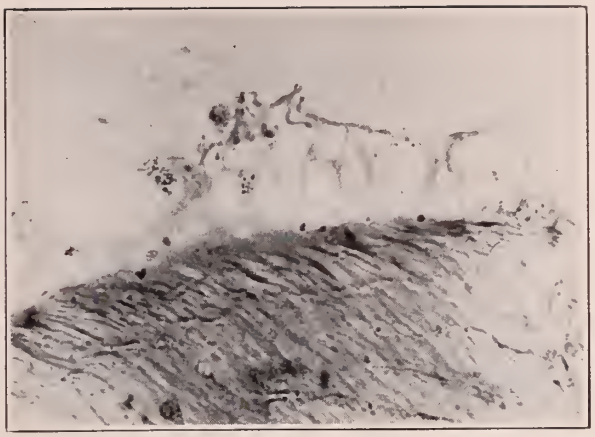


Fig. 3—Highpower view of the outer margin of the tectorial membrane showing frayed remnants of the delicate membrane of insertion. This is normally attached to the surface of the cells of Hensen. It appears net-like when detached but is probably continuous in situ.

Theory of Transmission of Sound Vibrations to the Hair Cells

The wave movements in the basilar membrane resulting from sound vibrations have been very thoroughly studied by many workers, who generally have sought to localize the wave movement at some point in the cochlear canal corresponding to the known location of the response to that tone. No one has succeeded in making any such localization. A large part of the basilar membrane responds to any given tone as does the organ of Corti, which rests upon it, rising and falling in a corresponding manner.

The up and down movement has been assumed by many workers to cause the hairs of the hair cells to impinge upon the inferior surface of the tectorial membrane or to, in some other way, make contact resulting in stimulation of the hair cells. These concepts seem untenable to me, since, if the up and down movement is as widespread as is now

generally accepted, it would be difficult to understand how this could result in a sharply localized stimulus. Secondly, it is difficult to conceive how two bodies, floating in the same fluid, could be made to impinge upon one another, because both would rise and fall equally with the fluid. Therefore, it seems to me that the concept of the up and down movement as the stimulating factor could profitably be abandoned. This does not mean that the wave movements are unimportant but simply that we must adjust our concept for their action.

Thorough study has been devoted to the rate of movement of the waves in the basilar membrane, as well as to the shapes of the wave patterns, and these workers agree reasonably well in their observations and mathematical calculations on the shape of the waves. It is a very striking fact that all of these waves are characterized by a sharp break directed toward the apex.

Since the organ of Corti lies on the inner half of the tectorial membrane, its movement is not strictly up and down. When seen in profile, it describes an arc. The center of rotation of this arc is located about in the floor of the inner sulcus. The arch of Held and its contained hair cells describe the same arc. The second arch, described above, fits closely over the arch of Held and rides upon it in the same type of motion. When observed in this type of motion, no relative movement can be detected between the two arches—they rise and fall together on an arc—and may I call to your attention again that the center of rotation of this arc is on the floor of the inner sulcus.

One member of the second arch, i.e., the mobile arch, has an independent origin. It is attached to the limbus at a point considerably higher than the floor of the inner sulcus. If the tectorial membrane were rigid and non-yielding, it would rise and fall upon another arc, having a center of rotation at the lip of the limbus. This would inevitably result in a shearing movement between the two arches. As a matter of fact, when observed, that portion of the tectorial membrane which spans the inner sulcus between the lip of the limbus and the insertion on the border cells is sufficiently yielding, through compression and stretch, so that it neutralizes shearing movements in an accordian-like fashion. Numerous previous workers have noted that the tectorial membrane, in contrast to the other structures within the cochlea, is more flexible (flexible apparently used to indicate the quality of yielding to forces of push and pull) transversely than longitudinally.

Now, where does all this lead us? A large part of the basilar membrane responds by an up and down wave movement to the sound vibrations of any given tone, as do the two arches which rest upon it, except that these, being located upon the inner half of the basilar membrane, describe a radially oriented arc rather than straight up and down movement. The second or mobile arch, although having an independent origin upon the limbus, nevertheless rides upon the arch of Held without any motion between them because the spanning portion of the tectorial membrane (inner half), by yielding to the shearing forces, prevents such movement.

If we look at the structures from above now rather than in profile, a very striking fact immediately becomes apparent. The tectorial membrane is supplied by oblique, fibrile-like structures, originating upon the limbus and extending outward and toward the apex at an angle of 30 to 40 degrees to the tangent of the spiral. They curve downward and are inserted in the contact zone of the tectorial membrane or in its outer margin. Some of them seem to originate practically at the lamina ossea itself. The lamina ossea and the limbus are comparatively firm structures. Moreover, the fibrils seem non-yielding to stretch, as evidenced by the fact that when point pressure is made upon the upper surface of the tectorial membrane an oval dimple results, with its long axis paralleling the fibrils. Further, a pull upon the sheet or membrane of insertion is very apt to result in a tear of the insertion; seemingly the fibrils do not stretch. However, when the basilar membrane moves up and down, generating radially directed forces, the accordian-like action of the tectorial membrane, which neutralizes these forces, can be readily seen. In this type of movement, the forces act across the axis of the fibrils at an angle of 60 or 70 degrees. Obviously in this direction the tectorial membrane is yielding. I have not actually observed diagonal movements, as on a slope directed toward the apex, but such movements must occur if the descriptions of the waves in the basilar membrane are correct. In such movement, the fibrils would be pulled "across the barrel," so to speak.

Let us make a hypothetical, simple picture. Assume that a single impulse comes into the scala vestibuli and increases the fluid pressure there. Then the tectorial membrane, the organ of Corti, and the basilar membrane would all be depressed in unison over a wide area. The tectorial membrane will now simultaneously be found in four different positions: (1) the original level, (2) a slope directed outward and toward the base, (3) another slope directed outward and toward the apex, and (4) a flat depressed zone between the two slopes. (Fig. 4) Shearing forces, produced because the tectorial membrane and organ of Corti are located upon arcs with different centers of rotation, would result. Those in the depressed zone would act in a radial direction; those upon the two slopes would act in

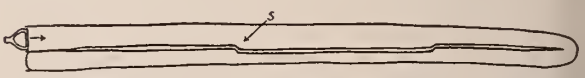


Fig. 4—Sketch of the cochlea unrolled to illustrate the situation of the hypothetical picture described in the text. The two lines represent the basilar membrane and the tectorial membrane. An impulse coming in from the stapes has depressed a section of these two membranes. According to the theory, the only place an effective stimulus would be found would be on the slope facing the apex at S.

directions varying between the radii of the cochlea and the direction of the long axis of the tectorial membrane. The direction of all of these forces, with one exception, would lie across the axis of the fibrils at angles from 60 to 90 degrees and would be neutralized by the transverse stretchable quality of the inner half of the tectorial membrane. At only one point, namely, the slope facing the apex, would the forces be directed in the axis of the fibrils. If the fibrils are as non-yielding to stretch as they seem to be, then a pull at the insertion of the fibrils would result because their origin is relatively fixed. This would cause a shearing movement between that portion of the tectorial membrane where the fibril is inserted and the adjacent portion of the organ of Corti. This could be the localized stimulating force which is applied to the hair cells—the localized spot for which we have looked so long. The resulting movement between the mobile arch and the arch of Held would be a diagonal shearing movement in the direction of the axis of the fibril. Such a movement would also cause a pull upon the insertion of the tectorial membrane on the cells of Hensen or upon the border cells or both. These mobile cells would yield enough to absorb the pull. They act like shock absorbers. At the termination of the impulse causing the depression, a movement of recovery would be initiated causing the structures to rise again to their former positions and above. The elastic structures, probably the spiral ligament as well as the cell masses of Hensen's cells and the border cells, would return the structures to their original relative positions. The physiologic action is probably not as simple as we have pictured it, but I believe that the principle of action is essentially as described.

This concept accounts for these anatomical facts:

- That the basilar membrane is fixed at its inner margin on a non-yielding, bony shelf, while the outer margin is suspended in space, as it were, by two elastic check ligaments. This permits of a limited up and down movement with a prompt return to the original straight position.
- That the organ of Corti is located on the inner half of the basilar membrane, where the up and down movement becomes hinge-like.
- That the arch of Held is supplied with a system of braces including the diagonal processes between Deiter's cells and the reticulum which render it relatively immobile. The sense cells located in such a supporting arch are thus subjected to a pull to which they may not yield.
- For the presence of two similar cell masses—Hensen's cells and the border cells. The difference in size of the two cell masses may be accounted for by the difference in amplitude of the movements which they must absorb.
- For the insertion of the tectorial membrane upon these two cell masses, Hensen's cells and the border cells, thus forming a mobile arch. The two abutments of this arch must be mobile to allow mobility between the two arches at the hair cells.
- For the presence of a small space between the ends of the hair cells and the inferior surface of the tectorial membrane in the contact zone—may we term this the articulating space. This space is spanned by the hairs and seems to be filled with an oily-like material which may act as a lubricant or may act as a roller bearing.
- For the presence of fibrils in the tectorial membrane, which originates on a relatively fixed base.
- For the fact that the tectorial membrane is more yielding transversely than longitudinally, a characteristic which is the reverse of that found in other cochlear structures.
- For the presence of a limbus upon which the tectorial membrane originates at a higher level than the basilar membrane.
- For the need for two separated centers of rotation.
- For the presence of a fluid-filled moat to the inside of the organ of Corti and under the spanning portion of the tectorial membrane. This allows space for the change in shape of this portion of the tectorial membrane and, at the same time, allows space for the organ of Corti to rotate.
- For some of the peculiarities of the wave pattern in the basilar membrane, i.e., that the wave has a flat top and a sharp break directed toward the apex.

There are other known anatomic facts for which this concept does not account, but the theory is not yet complete.

As in all theories, some assumptions are made, the primary one being that the fibrils are sufficiently non-yielding to sense the small physiologic sound movements which create a pull in their axis. The physiologic movements are presumably much smaller than those I have been studying and have described. Secondly, it is assumed that the fibrils are attached to or near the hairs of the hair cells in such a way as to transmit these impulses. No assumption is made as to the nature of the fibrils; they may, in fact, be tubes containing protoplasmic processes from the hair cells.

Summary

(1) The tectorial membrane has been found, in a study involving the dissection of 130 temporal bones, most of which were fresh, to be inserted at its outer margin on Hensen's cells and along Hensen's stripe upon the border cells.

(2) The ensemble of the mass of Hensen's cells on the outside, the mass of the border cells on the inside, and the tectorial membrane form a mobile

arch, the structure of which is very different from that of the arch of Held over which it fits closely.

(3) A theory of the transmission of the widespread sound vibration in the perilymph and basilar membrane to a small, localized area is presented.

---

626 Medical Arts Building.

REFERENCES

1. Békésy, V. G.: Contribution to theory of hearing. Mode of vibration of the basilar membrane, Phys Zeits. 29:793, 1928.
2. Ibid: The variation of phase along the basilar membrane with sinusoidal vibrations, J. Acoustic Soc. Am. 19:452, 1947.
3. Ibid: Direct observation of the vibrations of the cochlear partition under a microscope, Acta Oto-Laryng. 42:197–201 (June) 1952.
4. Bethes, A.: Handbuch der Normalen und Pathologischen Physiol. Bd. 11:497, 1926.
5. DeVries, von Hl.: Struktur und lage der tektorialmembran in der schnecke, untersucht mit neueren hilfsmitteln, Acta Oto-laryng. 37:334-338, 1949.
6. Hardesty, I.: On the proportions, development and attachment of the tectorial membrane, Am. J. Anat. 18:1–72 (July) 1915.
7. Ibid: On the nature of the tectorial membrane and its probable role in the anatomy of hearing, Am. J. Anat. 8:109–179, 1908.
8. Held, v. Hans: Handbuch der Normalen und Pathologischen Physiol. Bd. 11:467–534, 1926.
9. Hilding, A. C.: Studies on the otic labyrinth. I. On the origin and insertion of the tectorial membrane. II. A theory on the stimulation of the organ of Corti by sound vibrations, Am. Otol., Rhin. & Laryng. 61:354–384 (June) 1952.
10. Kishi, K.: Corti'sche membran und tonempfindungstheorie, Pflug. Arch. 116:112–123, 1906.
11. Kolmer, W.: v. Möllendorff's Handbuch der Mikroskopischen Anat. des Menschen Berlin, V. Julius Springer, Berlin 3 342–346, 1927.
12. Meyer, M. F.: How We Hear, Charles T. Bandford, Boston, p. 37, 1950.
13. Mygind, S. H.: Experimental-histological studies on the labyrinth, (XI) Correlation of our histological and clinical experiments and observations, Acta Oto-laryng. 35:108–129, 1947.
14. Perlman, H. B.: Observations through cochlear fenestra, Laryngoscope 60:77–96 (Jan.) 1950.
15. Peterson, L. C., and Bogart, B. P.: A dynamical theory of the cochlea, J. Acoustic Soc. Am. 22:-369, 1950.
16. Prentiss, C. W.: On the development of the membrana tectoria with reference to its structure and attachments, Am. J. Anat. 14:425–460 (May) 1913.
17. Ranke, O. F.: Theory of operation of the cochlea: a contribution to the hydrodynamics of the cochlea, J. Acoustic Soc. Am. 22:772, 1950.
18. Shambaugh, G. E.: A restudy of the minute anatomy of structures in the cochlea with conclusions bearing on the solution of the problem of tone perception, Am. J. Anat. 7:245–258 (Aug.) 1907.
19. Ter Kuile, E.: Die vebertragung der energie von der grundmembran auf die haar zellen, Pflug. Arch. ges. Physiol. 79:146, 1900.
20. Wegel, R. L.: Physical data and physiology of excitation of the auditory nerve, Ann. Otol., Rhin. & Laryng. 41:740–779 (Sept.) 1932.
21. Wever, E. H.: Theory of Hearing, New York, John Wiley & Sons, 1949.
22. Wittmaack, Karl: Uber bau und funktion der membrana tectoria, Acta Oto-laryng. 24:397-423, 1936.
23. Zwislocki, J.: Theory of the acoustical action of the cochlea, J. Acoustic Soc. Am. 22:778, 1950.

WISCONSIN PHYSICIANS TO BE FEATURED AT WATA MEETING

Several state physicians will be featured speakers at the 45th annual meeting of the Wisconsin Anti-Tuberculosis Association Thursday and Friday, April 23 and 24, at the Schroeder Hotel, Milwaukee.

The Wisconsin Trudeau Society, medical wing of the WATA, will meet Saturday, April 25, in connection with the WATA annual meeting. The preliminary program of the Society appears on page 189.

Dr. Donald E. Olson, Wisconsin General Hospital, Madison, will report on "Wisconsin TB Research," which he is conducting under a Christmas Seal grant from affiliated units of the WATA. He will speak April 24.

Dr. James M. Wilkie, medical director of Morningside Sanatorium, Madison, and Dr. Mary Broadbent, WATA, will be members of a panel discussing "TB Under Twenty," Friday afternoon. Sol Lifson, health educator from the National Tuberculosis Association will head the panel. Doctor Broadbent will present a report on results of a WATA tuberculin testing study.

The theme of the meeting, "TB—Still Unconquered," will be set Thursday morning by Dr. John Hanlon, Technical Cooperation Administration, Washington, D. C.

Besides Doctor Olson, the Friday afternoon medical session will feature Dr. Harold M. Graning, regional director, Public Health Service, Chicago, speaking on "Tuberculosis Among the Mentally Ill," and Dr. Ewald W. Busse, assistant professor of psychiatry, University of Colorado, Denver, on "Emotional Problems of the Tuberculous."

A special discussion on routine admission chest X-rays of general hospital admissions will be held Thursday afternoon by hospital representatives.

Dr. H. D. Ireland, medical director of Sunshine Sanatorium, Grand Rapids, Mich., will address a special interest session of social workers, Thursday morning.

"Getting Along with Ourselves" will be the subject of a Friday luncheon talk by Paul Mundie, consulting psychologist, Milwaukee.

Homicide as a Manifestation of Thalamic or Hypothalamic Disorder with Abnormal Electroencephalographic Findings

By EDWARD D. SCHWADE, M. D.* and OWEN OTTO, M. D.
Milwaukee

IN 1952, a male high school student killed a younger playmate by stabbing him a number of times in the chest. Following the killing, which occurred in the late afternoon, the youth hid the body of his dead playmate at his own home. He ate supper with his parents and spent the evening at home with them. Late at night, he removed the body and dragged it some distance away from his parent's home. The playmate was reported missing early in the evening, and an extensive search was made for him. Tracks and blood in the snow near the place where the body was finally found led directly to the patient's house and he was quickly apprehended by the police. He readily admitted his guilt.

The patient had been the source of some concern to the community on at least three previous occasions, and upon one of these occasions he had appeared before the Juvenile Court. A number of years ago, his next younger brother had drowned while playing in the water with the patient and another brother. His mother quoted the doctor at the time as saying that the brother did not die of drowning but of shock, possibly of cerebral hemorrhage. In addition, the doctor is said to have stated that he could have been pushed. The patient himself has never been able to give a consistent, coherent account of what happened. He has said only that he tried to save his brother, but got into a deep area and almost drowned himself before getting out. The death was considered to have been accidental. When questioned about it following the recent killing, he denied having had anything to do with his brother's death.

Three years ago, a 1½-year-old girl disappeared from the neighborhood. After prolonged and extensive search by the police and by the neighbors, the child was found in a creek leading to a nearby lake. She was found by the patient who had seen her floating at the bottom of the creek and had dived in to bring her up. She was pronounced dead by drowning, and the death was considered to have been accidental. When questioned about this death following the recent episode, the patient, on one occasion, admitted that he had pushed the girl into the water and had held her head under until she did not move any more. He related a wealth of circumstantial detail around this, but later took it all back, denied everything, and stated that he had made it all up. He then told the story of having seen her floating in the water. Though he was intensively interrogated, he never again would admit that he had had anything to do with this child's death.

A year later, the incident occurred which first brought the patient to the official attention of the Juvenile Court authorities. He had been playing "Daddy and Son" with a neighbor boy somewhat younger than himself, the patient being the "Daddy". Apparently the "Son" did something wrong and the "Daddy" punished him, using a piece of glass, however, instead of a stick. The boy was seriously lacerated about the neck; and the doctor who saw this boy is said to have felt that he had been choked before being cut with the glass. The Juvenile Court lectured the patient and ordered his parents to prohibit him from playing with younger children.

The patient's family background can best be outlined in the following manner. His mother has been married three times. Her first marriage ended in divorce after a year. There was one child from this marriage, a son, who is presently living with the family. Three years later, the mother remarried and again had a son who also lives with the family and goes under their name. The second husband is deceased. The son of this marriage has been on probation for larceny. The mother remarried for the third time to the patient's father in the 1930s. Of this marriage, there have been born five living children and one stillborn.

The patient's mother was brought up in a small town in Wisconsin, where her father had his own business. She describes herself as having been "Daddy's girl." She was the youngest of three children, and is now in her late forties. Her mother died of "dropsy" and her father of a "stroke." Her parents were deeply religious. At present, she is a large, corpulent and robust woman who makes a poor appearance and is poorly dressed. She likes to emphasize her own good upbringing and her high standards, which she is applying to her own family.

The patient's father is an elderly man who speaks in a mumbling manner. His wife states that he was the neighborhood drunkard and that she married him to spite the neighbors and because she knew that she could make a good man of him. At any rate, he has very little to say. He comes from a large family and finished only the third grade, hav-

* Director, Research Clinic Convulsive Disorders, Milwaukee County General Hospital and Mt. Sinai Hospital, Milwaukee, Wis.

ing had to go to work at an early age. His parents died while he was young, and he has had no contact with his siblings. Little detailed information could be obtained concerning his background. It is understood, however, that he is no longer a drunkard. According to the patient, his father is very strict and has mercilessly beat him with a stick. The father is a skilled worker in the construction business.

The patient was born prematurely and was one of twins, the other having died at birth or soon after. It is not known exactly what occurred at birth. According to the mother, she had fallen and injured herself and consequently went into labor, delivering at about six months gestation. The patient weighed under four pounds at birth. He is said to have remained in an incubator until three months of age and at the hospital until he was nine months of age. These facts have not been verified. He was bottle fed and is said to have walked and talked around the age of two years. He was not toilet trained until he was six years old. He had no unusual childhood diseases.

His mother describes him as a boy who has always kept very much to himself. She does state that, at one time, he would run in other people's gardens, pick flowers where he was not supposed to, and do many unusual things which she could no longer remember. He never did well in school and had to repeat a year of grade school. He has always shown a preference for playing with younger children and has not gotten on well with children his own age. According to the mother of the child whom he attacked with a piece of glass, the patient was always a quiet boy—not as loud as other children his age. She liked him because he was so quiet and cooperative. He talked a great deal about cooking and baking and helping his mother clean house. It appears that he was generally considered the neighborhood sissy. He was thought of as somewhat queer or different or backward, and he was not particularly well liked.

Following the killing, the patient's mother and father came quite strongly to his defense. His mother became quite resentful and blamed everyone involved for the trouble her son was in, *viz.* the school, the boys in his class, the neighbors, the police, the judge, and so forth. She openly accused her neighbors of all manner of things that were supposed to have contributed to her son's delinquency. Her talk was clearly defensive and at times almost appeared paranoid. His father gave the impression that what had happened must have been in some way the victim's own fault.

It is interesting to note that the mother gave as an example of her excellent management of her children the reading to them of a story that appeared in the paper which reported the killing of a laundryman by two boys and two girls. She explained to them that it does not pay to kill because one always gets found out in the end. She emphasized that, whenever she found things like this in the paper, she would read them to the children and explain the story, thereby hoping to prevent them from turning bad. She stated that she felt that this son was a good boy and that if he had done what he was accused of having done, he must have been very provoked.

On psychiatric examination, the patient appeared his stated age. He is moderately effeminate in his appearance and in his mannerisms. He is in good contact and oriented in all spheres. He is cooperative. While he states that he is perfectly at ease, he appears tense and restless and becomes quite upset when asked about the accident itself. His attitude is one of deference and obsequiousness. His mood is normal; emotional responses are considerably restricted; and he does not relate well. There are no gross psychotic manifestations. Intellectual resources are within the low normal range. He seems to have difficulty in abstracting and conceptualizing effectively and is concrete and circumstantial in his thinking. His memory is good.

He is able to recall all the incidents and circumstances of the recent past and can, when pressed, tell a coherent and rational story of the events which led up to the stabbing and of the events that took place afterwards. He admits to no lapses or gaps in his memory, nor are there any periods when he felt confused or vague about what was going on. However, the story he tells varies from examiner to examiner. To the district attorney, he related that the stabbing occurred after rectal intercourse with the younger boy, when this boy threatened to tell on him. He denied this story to the psychiatric examiner but was unable to give any motivation for it except to say that the boy was sassy. As has been mentioned before, he also told conflicting stories about the death of the 1½-year-old girl. He denies any knowledge about sex or homosexuality. He does not know what masturbation is and, when it is explained, he denies that he has practiced it.

During the psychiatric interviewing, he repeatedly stated that he felt very bad about what had happened but showed no appropriate affect. The reason he gives for feeling badly about it is that he was found out and it will spoil his reputation. The examiner felt he did not appear to express any real remorse or regret, and he acted as though he hardly appreciated the enormity of his act.

Medical history revealed no significant physical complaint. The patient denied any history of seizures, fainting spells, periods of confusion, or loss of memory. His parents corroborated him in this. General physical and neurologic examinations were within normal limits.

Electroencephalograms were performed two times —a week apart—and were identical. The background rhythm was 8 to 10 per second. In light drowsiness, light sleep, and deep sleep, there were frequent discharges of 6 and 14 per second positive spikes, confined mostly to the left temporal, left anterior temporal, left occipital and, to a lesser de-

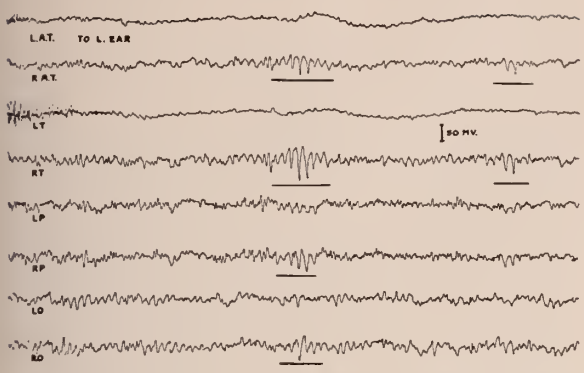


Fig. 1—Light sleep. To left ear, accentuating positive spiking, mainly six per second. Spread of focus to entire right hemisphere.

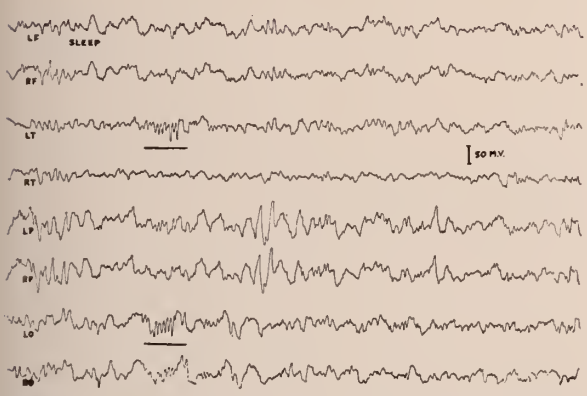


Fig. 2—Sleep. Fourteen per second positive spiking limited as focus to left temporal, left occipital a reas.

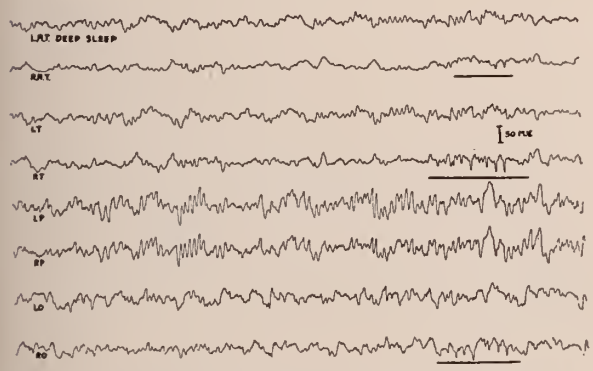


Fig. 3—Deep sleep. Six per second positive spiking as focus right temporal, right occipital.

gree, the entire left hemisphere. Occasionally, there was some positive spiking in the right occipital and temporal areas. The patient was entirely cooperative, appeared calm and without much anxiety, so that it was possible to get good sleep records on both occasions. The electroencephalographic diagnosis was 6 and 14 per second positive spiking focus left temporal, left anterio-temporal, and left occipital areas with mild spread.

The following psychologic tests were performed: the Wechsler–Bellevue Intelligence Scale; the Thematic Apperception test; the Rorschach test; the Sentence Completion test; the Story Completion test; the House-tree-person test; and the Bender Gestalt test. The Wechsler–Bellevue Intelligence Scale indicates that the patient is functioning at the dull normal level; verbal 79, performance 92, full scale intelligence quotient 83. There are suggestive indications that he has potential capacity at the low average level. It is significant that his performance on the Digit Symbol and Arithmetic subtests fell extremely low and that he had difficulty in completing the block design subtest. Poor performance on these subtests is generally considered to be indicative of organic brain disease and suggests a falling off of capacities involving organization and synthetic abilities. The Bender Gestalt test was within normal limits.

The psychologic tests revealed no evidence of any strong repressed hostility and aggression, nor was there evidence of impulsive violent acting out. Rather, they pictured an immature young man, deeply confused and bewildered in his sexual role, feeling depressed and isolated from others while wanting to be liked and accepted; obsequious in manner as an effort to gain acceptance; deeply narcissistic and incapable of relating to others; flattened and restricted in affect; and his thinking restricted to the concrete and lacking in conceptualizing and abstracting abilities. His hold on reality is precarious and there is much "magic in wishes" which makes it difficult for him to determine what is fantasy and what is real. There is, however, no evidence that he is deeply autistic, but rather his fantasy life appears to be superficial and related to desires of the moment.

Diagnosis: Sociopathic personality disorder, without psychosis, with 6 and 14 per second positive spiking in the electroencephalogram suggestive of thalamic or hypothalamic disorder.

Comment: The most significant finding in this case was the presence of 6 and 14 per second positive spiking in the electroencephalogram. This was considered to be indicative of neurophysiologic disorder of the thalamus which is associated with impairment of the inhibitor cortex. It is considered that, thereby, disorganized thalamic or hypothalamic impulses are released and permitted expression in unreasonable, violent behavior without any feeling other than the compulsion to act. One of us (E.D.S.) has collected a series of 46 cases in each of which there occur similar impulsive, unreasonable, frequently amnestic behavior episodes, associated with the electroencephalographic finding of 6 and 14 per second positive spikes. Impulsive and compulsive rage outbursts, with or without amnesia and confusion and with or without provocation, are characteristic of this group and appear to result from thalamic or hypothalamic disorders. This case is

the second of three homicides in this group of patients. In this case, the etiology of the thalamic disorder was probably a birth injury as evidenced by the patient's slow development physically and socially. At any rate, it has apparently existed all his life and has had a number of serious consequences for him. It has made it impossible for him to adapt successfully to life and he has always been a behavior problem. In addition, it appears to have made him unusually vulnerable to frustration and the emotional difficulties of life, so that when frustrated or displeased he may respond violently and unreasonably in a situation where such behavior does not seem appropriate or provoked. It must also be said that his rage outbursts can occur without any provocation whatsoever and that this may well have been the case with the homicide in question—the homicide being the violent manifestation of a rage outburst.

Summary

The case of a homicide committed by a boy of high school age has been presented. The most significant finding is the presence of 6 and 14 per second positive spiking in the electroencephalogram. This finding is considered to indicate thalamic or hypothalamic disorder, and the homicide is considered to be the manifestation of a rage outburst resulting from the neurophysiologic disorder. This case is one of a group of cases manifesting violent, impulsive rage outbursts with evidence of thalamic disorder, *viz.* the finding of 6 and 14 per second positive spiking in the electroencephalogram.

(E. D. S.) 324 East Wisconsin Avenue.

THE AMERICAN COLLEGE OF ALLERGISTS

The annual conclave of The American College of Allergists will be held this year at the Conrad Hilton Hotel in Chicago, April 24 to April 29.

The first four days will be devoted to instruction under the tutelage of recognized authorities and the last three to a discussion and reporting of recent advances in the field of allergy by the investigators themselves. For detailed information write The American College of Allergists, La Salle Medical Building, Minneapolis 2, Minnesota.

ROCKY MOUNTAIN CANCER CONFERENCE TO BE HELD JULY 8 AND 9

The seventh annual Rocky Mountain Cancer Conference will be held in Denver on July 8 and 9. As in previous years there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their ladies. There is no registration fee for this Conference.

Further information may be obtained by addressing Mr. H. T. Sethman, executive secretary, Colorado State Medical Society, 835 Republic Building, Denver, Colorado.

Protein Needs in Children, Premature and Pre-school Groups*

By E. T. Mc ENERY, M. D.
Chicago, Ill.

PREMATURE infants present many problems. The smaller they are the more complex the situation. Their care has been greatly improved with a better understanding of their physiology, pathology, and nutritional requirements. Nursing technic has also progressed, and better understanding of the use of incubators, oxygen, and humidity has created a better and more physiologic environment for them. The question of their nutritional requirements and how they should be met is controversial. Every infant is a problem in itself.

One of the most serious handicaps of the premature infant is the low protein content of the body. The majority of infants who survive are born after the thirty-second week of gestation and weigh about 1,500 Gm. The normal infant during the ninth and tenth lunar months will gain 1,000 Gm., of which 155 Gm. are protein. If the premature baby is to maintain this rate of growth and development after birth, as it would have in utero, its need and retention of protein are very great.

Gordon[1] and his associates showed that more nitrogen was retained as the protein intake was increased from 2.8 to 5 Gm. per kg. daily. By feeding high protein formula, it has been demonstrated that these infants maintained levels of nitrogen balance much better than older infants who were fed similar feedings. The protein requirement of these infants is very high in order to provide maintenance of body function and to obtain suitable growth and development. This evidence suggested that the heightened retention of protein in young infants is related to their increased rate of growth.

In chart 1, we see the increase in weight over a period of one year in the small and medium size premature babies as compared to the normal infant.

In the past, the consensus has been that breast milk was the superior food for premature infants, but breast milk is very low in protein. Doctor Magnusson[2] has shown that small infants do better when breast milk is fortified by a protein hydrolysate. He demonstrated that in the premature infant, fed with breast milk and a protein hydrolysate, a gain in weight was obtained which practically doubled the weight gain of those infants on breast milk only.

To meet the protein needs of the premature infant, it has been shown that since the content of breast milk is low in protein, the infant would have to take 4¾ oz. of breast milk per pound baby weight per day. This quantity would certainly be over feeding the infant on a bulk basis and would soon lead to an untold amount of gastrointestinal disturbances.

Doctor Hess,[3] in discussing the metabolism of the premature infant, states that at least a portion of the gastrointestinal tract is immature, intestinal motility is below normal, and absorption of food is poor. The normal digestive enzymes are present in reduced amounts. This leads to slow and improper digestion and absorption of food.

Doctor Werner,[4] in studying the enzymatic action on protein digestion in the premature infant, came to the conclusion that it would be advisable to add protein hydrolysate to the food of premature infants.

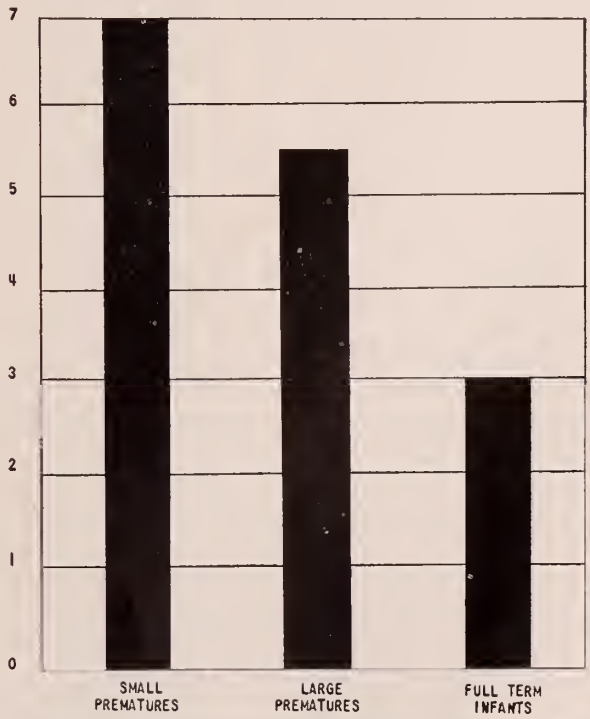


Chart 1—Weights of small premature infants, large premature infants, and full term infants at end of first year of life in relation to birth weights. Small premature infants must increase their birth weights seven-fold during the first year of extrauterine life; large premature infants must increase their birth weights over five-fold; and full term infants must grow only enough during the first year to increase their birth weights three-fold. (Based on data from Hess, J. H.: The Premature Infant, Philadelphia, J. B. Lippincott Company, 1941, chap. 3, p. 19.)

*Presented before the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952.

Doctor Jorpes[5] and his associates fed 100 premature infants on a formula of breast milk with an added enzymatic casein hydrolysate and dextrose mixture. They tolerated the mixture well, and there were no apparent signs of digestive disturbances. All premature infants on this mixture showed greater gains than those on breast milk alone. Doctor Smellie[6] recently reported the experiments on 55 premature babies receiving breast milk or breast milk with the addition of a mixture of amino acids and peptides, resulting from casein hydrolysate. Such addition to the formula caused definite improvement in the weight gained by these infants receiving the supplement. The amino acids seemed to be well utilized.

With the above data at hand and an opportunity to observe a large number of premature infants (approximately 500) over a period of three years, we developed the following technic in caring for them. All babies were considered premature whose weight was five pounds or less. On being admitted to the nursery, these infants were placed in a small premature unit using incubators which supplied them with proper amounts of heat, oxygen, and humidity. Careful nursing and supervision was given. Nothing was given by mouth for at least 30 hours. In some cases, if edema was present, it was withheld for longer periods. We believe, as Smith does, that all premature infants do better physiologically on a dehydration program during the first few days. After this period of dehydration and close observation, we feel that the infant can swallow and has a good sucking reflex. A weak solution of tea is started with a medicine dropper. After 24 hours, if the infant is taking this fiuid without any difficulty, we feel that some stronger formula can be given.

At this point we attempted to determine the optimum formula for these infants. We decided to try several formulas; pooled breast milk, evaporated milk, and sweetened evaporated milk were tried over varying periods of time. A good average weight gain and a general physical response to these feedings were obtained. We then added casein hydrolysate to each of these formulas and made the same observation. The breast milk was difficult to obtain as the nursing mother remained in the hospital for only five days, and it was not possible to have enough breast milk available for many of the babies. However, we occasionally had a mother of a premature baby who had an abundance of milk, and we were able to take care of several infants. The casein hydroylsate that we used was Protolysate.* This is the principal protein of cows milk which has been produced by enzymatic hydrolysis. In contains all of the 10 amino acids. The nitrogen content of Protolysate is 75 per cent of that of intact protein. Thus 1 level tablespoon of Protolysate is equivalent to 6 Gm. of protein. One level tablespoon supplies 30 Gm. of calories.

* Supplied by Mead Johnson & Co., Evansville, Indiana.

A typical result of the babies' gain in weight is demonstrated in chart 2 which shows the increased gain in weight after adding the protein hydrolysate to the breast milk. Similar results were obtained in reference to evaporated milk. Our best results were obtained when we added the protein hydrolysate to the sweetened evaporated milk. Here was a diet high

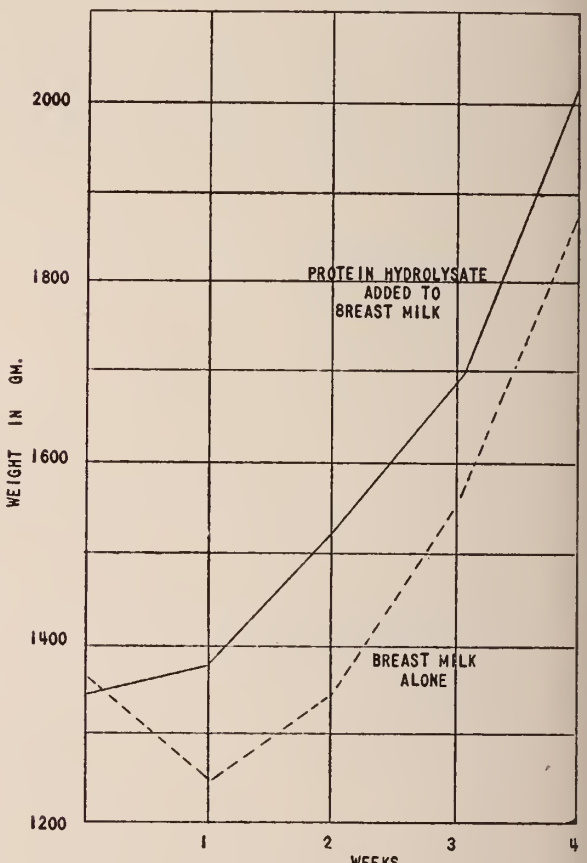


Chart 2

in protein, low in fat, and containing a carbohydrate value that was higher than that in either breast milk or evaporated milk. This gave us a high caloric value, about 100 calories. The infants gained more rapidly, and there was no gastric distress, vomiting, diarrhea, or abdominal distention. Powers,[7] writing on his observation in the feeding of premature infants, admits that this is a well tolerated feeding formula for premature infants despite almost universal condemnation.

Our plan of feeding these infants has been worked over with many types of milk, and we have adopted the following routine. If the mother has breast milk, we use it, fortified by Protolysate; if there is no breast milk available, then we use the sweetened evaporated milk, diluted 1 to 10 and fortified with Protolysate. This is given in small amounts, a few drops at a time, increasing it as the infant tolerates it and usually feeding every 2 to 3 hours. If the infant tires greatly during the feeding process, we resort to gavage feeding. After the first

two weeks suitable vitamins, such as D and C, are added. Iron is also given at the end of the first month. The criteria for discharge from the hospital is a weight approximating five pounds eight ounces.

This feeding outline can be followed until solid foods are added at three to four months, when it is advisable to change to another type of milk and the Protolysate can be discontinued.

This plan of feeding has not been fostered with the idea that it is the only one which supplies the nutritional needs of the premature infant; but we feel that it has been used on a sufficiently large enough series of babies and for a long enough period of years to recommend it as a safe, simple, and economical plan for feeding the premature infant.

The second portion of this paper has to do with the preschool child, so frequently seen in the physician's office. The chief complaint is from the mother, "my child won't eat." It seems to be a crying problem of the well-to-do American family. The complete picture is the child who will not eat meat, vegetables, cereals, or fruit but will take sweets, cookies, soda-pop, ice-cream, and drink a large amount of milk. He is whiney, restless, cries easily, pale and pasty, active, and wants to be on the go all the time. He has not responded with any desire for food from scolding, threatening, punishment, bargaining, coaxing, or tonic. In other words he is not a sick child, but he is a "problem child."

This term is used too often and has too wide a base to cover our situation. This child is sick because he is suffering from hypoproteinemia, a term well selected by Lynch and Snively.[8] You are well aware of this situation and know that the answer is too much milk and too little protein foods. The child drinks quantities of milk, one and a half to two quarts daily. This amount satiates his hunger call, and so why should he bother about all the other food requirements necessary for proper growth and development.

The child at this age is too much interested in play and in the investigation of all the new things about him. His fields of experience are widening, and these should not be curtailed.

This situation can only be approached through proper guidance of the mother. She it is who can be blamed for most of this turmoil at meal time. First she should be instructed that growth and development slow down greatly after the first two years. If this rapid growth during the first and second year was to continue the child would be a "Man Mountain." Nature has provided a slowing down of the growth process, and hence the child does not need so much food.

This eating problem occurs on the farm and in the city. It occurs in the only child more frequently than in the large family. These children like too highly concentrated foods, quick energy foods, sweets and starches, and their diet lacks sufficient protein. True protein is present in milk, but the quantities needed by these youngsters cannot be supplied by milk alone; it must come from meat, fish, poultry, and cheese.

After the growth situation has been explained to the mother, it is then necessary to tell her that too much attention should not be paid to the child at the table if he will not eat. The cooperation of the father is necessary and scenes at the table should be avoided. Small portions of meat and vegetables, in their simplest form, with a 5 oz. glass of milk and a plain desert or fruit is all that it is advisable to serve. If the child refuses this food, he should be excused from the table and allowed to go hungry; he will not starve before the next meal. Piece eating between meals for this type of child is not to be a substitute. With firmness in following a new program, the child will soon realize that his hunger pains must be satisfied and he will eat what is placed before him.

The majority of children are much wiser than their parents admit. The child will obtain attention for himself by bad habits. Sometimes these annoying situations bring quicker results when good ones fail. Frequently the problem of eating involves more of the family than the parents and, today, with living quarters at a premium, some young people have to live with the in-laws and relatives. These situations have to be handled with a great deal of tact, otherwise the child is in the center of the conflict and he suffers more than the family.

This situation cannot be corrected by the use of tonics or multi-vitamins. The basic needs must be understood and time must be taken to explain these needs to the parents. The process is time consuming. In the long run, no therapeutic measures give more relief to the family and more satisfaction to the physician than the correction of the feeding problem. My plea is do not allow the eating habits of children to become such an important factor of every day life. If a child is not ill, he will take care of his nutritional needs if food is supplied to him. This fact was demonstrated by Dr. Clara Davis, years ago, in a series of babies fed on a self-selected diet. This same plan was used successfully in a convalescent ward at Children's Memorial Hospital in Chicago. It was not only good for the children but the wastage of food was less.

Some parents have the idea that children should not eat much meat. Meat supplies the needed protein for growth, activity, and development, which cannot be met by a high carbohydrate diet.

Prophylactically, we have to do a lot of work to correct this situation. The management of these problems centers about the mother. This factor must be dealt with by proper education. If the mother's ideas, plans, and preparation of meals can be corrected and guided, the child will not develop peculiar eating habits. Hypoproteinemia in the preschool child demands proper guidance.

4458 West Madison Street.

REFERENCES

1. Gordon, H. H., Levine, S. Z., and McNamara, H.: Feeding of premature infants; comparison of human and cow's milk, Am. J. Dis. Child. 73:-365–380 (April) 1947.
2. Magnusson, J. H.: La mezcla de aminoacidos en la alimentacion de los prematuros, Rev. espan. Pediat. 4:234–251 (March–April) 1948; Abstracted, Nutrition Abstr. and Rev. 18:400, (Oct.) 1948.
3. Hess, J. H.: The Premature Infant, in Brennan, J.: Practice of Pediatrics, Hagerstown, Md., W. F Prior Company, 1943, vol. 1.
4. Werner, B.: Pepsin and pancreas proteinase in premature as compared with full term infants, Ann. pediat. 170:8–14, 1948.
5. Jorpes, E., Magnusson, J. H., and Wretlind, A.: Casein hydrolysate; a supplementary food for premature infants, Lancet 2:228–232 (Aug. 17) 1946.
6. Smellie, J. M.: Amino acids in feeding of infants, Arch. Dis. Childhood, 23:98–101 (June) 1948.
7. Powers, G. F.: Some observations on feeding of premature infants based on 20 years' experience at New Haven Hospital, Pediatrics 1:145–158 (Feb.) 1948.
8. Lynch, H. D., and Snively, W. D., Jr.: Hypoproteinosis in childhood, J.A.M.A 147:115–119 (Sept. 8) 1951.
9. Albanese, A. A.: Protein and amino acid requirements of infants, Pediatrics 8:455–462 (Oct.) 1951.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES POSTGRADUATE COURSE

"Advances in Internal Medicine" is the title of a postgraduate course offered by the University of Wisconsin, April 21, 22, and 23. This course, under the direction of Dr. O. O. Meyer, features lectures and conferences covering a fairly broad field of medicine—both by way of review and with respect to recent changes in technics of diagnosis and choice and conduct of therapy. It will contain a great deal of information which will be immediately useful to the doctor with regard to conditions he frequently meets in his everyday practice.

Tuesday, April 21

A. M.

8:00 Registration
9:00 Peptic Ulcer—Dr. K. L. Puestow
10:00 Carcinoma of Stomach and Colon—Doctor Puestow
11:00 X-Ray of the Gastrointestinal Tract—Dr. L. W. Paul

P. M.

1:00 Liver Disease—Dr. J. L. Sims
2:00 Renal Disease—Dr. W. S. Middleton
3:00 Arthritis—Dr. O. O. Meyer
4:00 Clinical Pathological Conference — Dr. D. M. Angevine and Staff

Wednesday, April 22

A. M.

9:00 The Antibiotics—Dr. A. S. Evans
10:00 Rheumatic Fever—Dr. C. M. Kurtz
11:00 Cardiac Arrhythmias—Dr. H. H. Shapiro

Wednesday, April 22

P. M.

1:00 Coronary Artery Disease — Dr. C. W. Crumpton
2:00 Congenital Heart Disease—Dr. J. E. Gonce
2:30 Surgical Considerations in Congenital Heart Disease—Dr. J. W. Gale
3:00 Diseases of the Thyroid—Dr. E. C. Albright

Thursday, April 23

A. M.

9:00 Non-Tuberculous Pulmonary Diseases—Dr. Helen A. Dickie
10:00 Present Therapy of Pulmonary Tuberculosis—Dr. J. K. Curtis
11:00 Psychosomatic Disease—Dr. M. J. Musser

P. M.

1:00 Dermatologic Diseases—Dr. S. A. M. Johnson
2:00 The Anemias—Dr. R. F. Schilling
3:00 Hypertension—Doctor Crumpton
4:00 X-Ray Conference—Dr. L. W. Paul and Staff

The course is limited to 45 persons and advance registration will be necessary for attendance. The fee is $10. Address inquiries to R. C. Parkin, M. D., University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

Antihistaminic Drugs in Dermatology*

By JAMES J. BARROCK, M. D.
Milwaukee

SINCE the discovery of the first antihistaminic drug many similar drugs have been developed. Some have been studied extensively and have been tried in innumerable cases of diseases which seemed to have an allergic background. The purpose of antihistamines is to nullify or to inhibit the histamine wheal response and to neutralize the effect of histamine after it is formed in the skin of allergic humans. Histamines play a prominent role in the phenomena of hypersensitivity. Allergic reactions in tissue cells are due to the liberation of a histamine-like substance. This is followed by a dilation of the capillaries producing a loss of plasma protein and fluid through the capillary walls into the extracellular spaces. The advent of the antihistamines has greatly aided in the management of many dermatoses of allergic and even non-allergic origin. These drugs reduce the manifestations of many cutaneous diseases and offer the patient symptomatic relief.

There is great difficulty in interpreting the clinical value of the antihistamine drugs because the exact mechanism of action of the antihistamine drugs is unknown at present. All patients do not exhibit similar sensitivity reactions nor does a patient react similarly on successive occasions. The factors which modify physical and mental sensitivity are so numerous that it is extremely difficult to come to a proper evaluation. Important are the patient's previous experiences with antihistaminic drugs. Each patient should be asked whether he has taken some antihistamine before and the effect that it produced. The antihistaminic drugs, especially when used as ointments, first show satisfactory results but later prove to be sensitizers. Since the value of these drugs in the treatment of certain skin diseases has been so positively established, it would be poor judgment to refrain from using these antihistaminic drugs because of the difficulty in selecting the one best fitted to the individual patient's need.

In 1933 Fourneau and Bovet[1] demonstrated a substance which would neutralize the effect of histamine in living tissue *in vitro*, but it was found to be very toxic for human beings. In 1937 Bovet and Staub[2] discovered a new drug called Antergan, but this also was too toxic for clinical use. In 1942 Halpern[3] further modified Antergan, and this newer synthetic substance was found more powerful and less toxic than the earlier products so that it was safe for clinical use. Antergan was later replaced by Neo-Antergan which was even less toxic and more potent.

In February 1945, Loew, Kaiser, and Moore[4] discovered Benadryl. This was the first relatively nontoxic but effective antihistamine. A few months later in 1945 Mayer, Huttrer, and Scholtz[5] introduced Pyribenzamine, the second nontoxic antihistamine. Feinberg[6] reviewed the use of antihistaminic drugs developed up to 1946, and described the successful use of Benadryl and Pyribenzamine.

The general formula for antihistamines is R–X–C–C–N–[7]. R indicates a variety of benzene or heterocycle structure containing carbon, hydrogen, and often nitrogen, sulphur, or oxygen. X may be nitrogen, oxygen, or carbon. When X is nitrogen, the best examples are Pyribenzamine, Pyrrolazote, and Thenfadil. Most commercial antihistamines belong to this group, representatives being Thenylene, Neo-Antergan, Neohetramine, and Histadyl. They are the most active antihistamines. When X is oxygen, the best examples are Benadryl and Decapryn. When X is carbon, good examples are Trimeton and Chlor-Trimeton Maleate. The fourth group has Antazoline Hydrochloride or Thonzylamine Hydrochloride as seen in Antistine. This last group have the lowest untoward side effect but give a smaller measure of relief. Pyribenzamine is essentially an amine. Benadryl is closely related, but the hub of the molecule is carbon instead of the hydrogen atom. Thephorin has no relation to either. It has a complex ring structure based on pyridindene. They all have a similar pharmacologic action but differ in potency and toxicity.

The drugs in order of their effectiveness in relieving pruritus and allergic symptoms are:

(1) Pyribenzamine: N'pyridyl–N' benzyl–n–dimethyl–ethylenediamine monohydrochloride (Ciba)
(2) Benadryl: Beta–dimethylaminoethyl benzhydryl ether hydrochloride (Parke, Davis & Co.)
(3) Chlor-Trimeton Maleate: 1–(P–chlorophenyl)–1–(2–pyridyl)–3–N,N–dimethylpropylamine maleate (Schering)
(4) Pyrrolazote: Beta–pyrrolidineethyl–phenothiazine mono–hydrochloride (Upjohn)
(5) Thephorin: 2–methyl–9–phenyl–2,3,4, 9 tetrahydro–1 pyridindene hydrogen tartrate (Hoffman–LaRoche)
(6) Histadyl: N,N– dimethyl–N' (2–thenyl)–N'(2–pyridyl)–ethylenediamine hydrochloride (Lilly)
(7) Neo-Antergan: N–P–Methoxybenzyl–N–N–dimethyl–N–a–pyridylethyl enediamine maleate (Merck)

* Presented before the Metropolitan Dermatological Society, Chicago, on March 12, 1952, and also before the eight International Cruise–Congress of the Pan American Medical Association, January 14, 1953.

These seven are the most commonly used antihistamines in our office. Other common antihistamines are as follows: Trimeton, Hydryllin, Thenylene, Diatrin, Thenfadil, Decapryn, and Phenergan.

Long acting antihistamines are the chlorcyclizines, such as Perazil (Burroughs Wellcome) and Di-Paralene (Abbott); and repeat action Chlor–Trimeton Maleate (Schering) and Phenergan (Wyeth). Their action is about 8 to 12 hours while the average antihistamine acts for about 4 to 6 hours. The pruritus subsides usually within one-half hour after the administration of the drug.

Benadryl, Histadyl, and Chlor–Trimeton Maleate are also given intramuscularly and intravenously, producing actions that are more prompt and are more powerful in action. When antihistamines are given intravenously, the patient experiences a feeling of warmth to the head, neck, and throat. On arising from the recumbent or sitting position, the patient often encounters a feeling of vertigo, light headedness, nausea, and weakness.

The most sedative antihistamines are Benadryl, Decapryn, and Phenergan. When a patient is helped by Benadryl, the sedative effect of the drug is usually apparent.

The actual value of antihistamines in man is determined by the clinical response. The value of the antihistamine is evidenced by (1) prompt alleviation of symptoms, (2) recurrence of symptoms upon withdrawal of the drugs, and (3) the substitution of the drug with a placebo which fails to elicit relief.

Antihistamines provide symptomatic not curative relief for allergic diseases such as rhinitis, asthma, urticaria, atopic dermatitis, serum sickness, and pruritus ani. At times they may produce a flare up of the dermatitis or allergic disease present.

Antihistamines are marketed as capsules, tablets, syrups, elixers, lotions, (Caladryl and Phenergan lotion with neocalamine) creams, ointments, ophthalmic and nasal drops, and in solution for intramuscular and intravenous administrations (Benadryl, Histadyl, and Chlor-Trimeton Maleate). Ten per cent of the ingested or intravenous antihistamines are excreted from the body within 24 hours.[8] Most antihistamines are given in a dosage of 2 to 50 mg. three times a day after meals and before retiring. One strives to limit the dose to the smallest effective amount. As the severity of the symptoms diminish, the dose is decreased. If the initial dose is not responsive, the amount of the drug may be increased or it may be necessary to give another type of antihistaminic drug.

Antihistamines are helpful in the following allergic and nonallergic dermatoses.

Acute Urticaria is often a definite allergic response to a single food or drug which can be elicited from the history. The attack develops within a few minutes to a few hours following the ingestion of the offending substance. Antihistaminics give very favorable results in acute urticaria. Sherman[7] benefited 70 to 90 per cent of his patients with acute urticaria by giving antihistamines. Feinberg[6] found antihistaminics to be effective in urticarial dermatoses as well as in dermographism. Schaffer[9] experimented with Benadryl in 8 cases of urticaria and relief was obtained in 7 cases in a very short time. Curtis and Owens[10] gave Benadryl to 18 patients with urticaria and helped 14 patients. Spain and Pflum,[11] in a series of 493 patients, benefited 80 per cent of their urticarial cases with antihistaminics. Peshkin[12] and his co-workers reported excellent response in 46 out 47 cases of urticaria. Seidmon[13] and Wright[14] prescribed Chlor–Trimeton with success in urticaria. Waldriff, Davis, and Lewis[15] found the urticarial lesions disappeared in 80 per cent of their cases. In our own experience in two instances of urticaria due to physical allergy to cold, the administration of Thephorin resulted in chills. When Thephorin was replaced by Pyribenzamine, no such reaction was noted. The average dose may suffice, but in some cases it may be necessary to increase the dose to two or three times the average dose, and this is to be repeated three to four times a day, decreasing the amount of medication as relief is obtained. In severe forms of urticaria, intramuscular or intravenous injections of Benadryl, Histadyl, or Chlor–Trimeton are more effective than oral medication. Where intolerable itching is present, as in urticaria, Benadryl, Decapryn, or Phenergan are the drugs of choice. Neo–Antergan and Pyrrolazote also gave good results. Relief of itching is obtained, but the wheals may persist although smaller in size and with the erythema lighter in color. Treatment of all causative factors should always be carried out in addition to the antihistamines. Very good results were obtained when calcium gluconate and antihistamines were given together intravenously. Calcium gluconate given orally with an antihistaminic also is effective. It may also be necessary to give ephedrine in oil subcutaneously in more stubborn cases. Failures may be due to improper dosage and too early cessation of treatment. Even in those failures relief is again often obtained when the drug is readministered. Success in treatment may be due to additional factors such as spontaneous recovery, local topical applications, rest, sedation, starch baths, and oatmeal baths (Aveeno).

Chronic Urticaria: To this condition the response is less effective (50 per cent to 70 per cent), but antihistamines do give symptomatic relief. Doses as large as 75 to 100 mg. three to four times a day are necessary. It is necessary in these instances to search for some internal disorder or neurogenic disturbance.

Angioneurotic Edema or Giant Urticaria is less susceptible to these drugs as it is to older forms of therapy. Halpern[16] obtained good results in 16 out of 19 patients with angioneurotic edema by giving Phenergan orally. In acute attacks large doses of antihistamines given orally or injected parenterally are used together with epinephrine in oil. It is most important here to take a careful his-

tory, to determine the possible etiology. Pyribenzamine, Benadryl, Trimeton, and Chlor–Trimeton also help in some cases to give the patient relief. Sedatives and calcium should be employed with the antihistamines.

SERUM SICKNESS and PENICILLIN REACTIONS: Urticarial reactions may develop one or two weeks following the injection of penicillin given intramuscularly or intravenously, or may develop shortly after the first injection of a second series given weeks or months after the first series. Large doses of antihistamines are required and are given intramuscularly or intravenously for the relief of the pruritus and urticarial reactions due to penicillin. The response has been very good when the antihistamines are given in conjunction with calcium gluconate or adrenalin. The fever and joint pains of serum reactions are not affected by this form of medication. It may be necessary to use corticotropin (ACTH) or cortisone to give better results. The beneficial effects of antihistamine therapy takes place within 12 hours after treatment is started. If there are no definite improvements after eight hours, one should employ another antihistamine or combination of two or more antihistamines.

LOCALIZED or CIRCUMSCRIBED NEURODERMATITIS (Lichen Vidal): Benefit from antihistamine is unpredictable here. No favorable results or good responses of 75 per cent of the patients with a localized neurodermatitis of the upper eyelids, to the sides of the neck, and to the calf of the legs has been reported. Some of the patients treated with antihistaminic creams locally and antihistamines orally obtained slight relief of the itching, but there was no immediate change in the appearance of the skin lesions. In some cases an aggravation of the dermatitis developed. The pruritus increased and the patient had to discontinue the medication. Control of the itching constituted an important part of the treatment. In severe itching the use of Benadryl, Decapryn, or Phenergan for sedative effect was necessary. The topical application of Perazil cream produced a definite relief of the itching, especially to the eyelids. Bereston[17] used Histadyl cream in 104 patients where pruritus was the cardinal symptom, and temporary relief was obtained in 40 per cent of his patients. No contact dermatitis developed from the Histadyl or the carbowax base. Ellis and Bundick,[18] in making an appraisal of the value of antihistamines from the replies of 200 dermatologists, found the local use of antihistamines to be of value in localized neurodermatitis and anogenital pruritus and of least value in moist areas. The overall incidence of sensitization was 8.8 per cent.

DISSEMINATED NEURODERMATITIS (Atopic eczema): Oral medication of antihistamines gave about 50 per cent relief, while, locally, antihistaminic ointments and creams gave some relief from scratching. Elixer Pyribenzamine, elixer Benadryl, elixer Tussate, syrup of Chlor–Trimeton, and syrup of Histadyl are useful as adjuncts in infantile eczema. Waldriff[15] gave Histadyl for atopic eczema with good results.

DERMATITIS VENENATA (Contact Dermatitis): Some relief of itching was obtained by the oral administration of the antihistamine drugs in dermatitis venenata. Benadryl, Thephorin and Pyrrolazote were employed with variable success. The response was not too satisfactory. The local application of antihistamines in contact dermatitis is not advisable as the incidence of sensitivity and consequent flare up of the dematitis is high. Phenergan lotion with neocalamine resulted in some relief of itching when applied locally in 16 cases of poison ivy. The burning sensation was encountered in the application of Benadryl cream for insect bites. The pruritus decreased following the application of this medication.

ERYTHEMA MULTIFORME: Relief from itching was striking when antihistamines were given orally in 3 cases of erythema multiforme. Lynch[19] and Foster[20] gave Benadryl orally and intravenously for erythema multiforme, and an improvement was noticed within 24 hours.

PHYSICAL ALLERGY: Pronounced relief was obtained by giving Thephorin orally for a cold allergy involving the hands and fingers. There was a decrease in the erythema, edema, burning, and itching sensation of the fingers and hands. Notier and Roth[21] reported a case of hypersensitivity to cold where relief was obtained by the oral administration of Benadryl. Thephorin was also given orally, with an excellent response, to alleviate the itching in a patient who exhibited dermatitis vacciniformis.

INFECTIOUS DISEASES: Elixer Benadryl was given orally to help stop the itching in chickenpox and measles. The relief of itching stopped the children from removing their scabs prematurely, thus preventing the formation of pox scars.

HYPERHIDROSIS: Osborne, Jordon, and Rauch[22] and Andrews[23] obtained prompt relief with Pyribenzamine in patients with hyperhidrosis.

PRURITUS ANI, VULVAE, and SCROTI: Orally, the antihistamines have proven of little value in the treatment of pruritus ani, vulvae, and scroti. Locally, antihistamines as a 2 per cent ointment in a water soluble base are of some help in pruritus ani, vulvae, and scroti. A small area of skin should be treated to determine local sensitivity before the medication is applied to larger areas. Foster[20] has discontinued the use of antihistamine ointments and creams because the results are not encouraging. Frankfeldt[24] gave Pyribenzamine orally in varying doses of 50 to 100 mg. after meals and at 10:00 p.m. for pruritus ani. He later reduced the doses to one tablet before retiring to insure uninterrupted sleep. He also used 2 per cent Pyribenzamine in a water soluble base with fair results. This local application produced a smarting sensation when first applied. There is a relatively high incidence of sensitization to the local application of antihistamine cream and ointments. Waldriff[15] used antihistamine locally with

success in pruritus ani. It is extremely important to look for the probable causes of the pruritus, among which are the following: (1) allergic manifestations to foods (particularly such foods as oranges, chocolate, eggs, and beer); and (2) infection, both bacterial and fungus infections, particularly moniliasis. Intestinal parasites must also be considered; (3) neurogenic factors; and (4) dermatitis venenata from enemas, douches, medication, toilet tissue, talcum powder, perfumes and dyes. Bleaches such as clorox or other chlorine solutions used to bleach clothes must also be kept in mind. These causative factors must be corrected if antihistamines are to be effective. Relief in pruritus ani is due to the local anesthetic action of the antihistamine. It is procaine-like in effect. Benadryl, Pyribenzamine, and Neo-Antergan are two or three times as effective as procaine. Sedation helps to control the patient's itching and is of value in insomnia due to allergic states. When the itching is controlled, the patient is more comfortable and scratches less. This reduces the trauma due to scratching and prevents secondary infection. Correction of these factors promotes healing and shortens the course of the dermatitis. Antihistamines do not cure the lesions. They are palliative and not curative.

Side Reactions

Side reactions vary with dosage and individual tolerance. The dose should be regulated to produce relief from the symptoms without causing any undesirable side reactions. Reactions are most common in patients taking large doses of antihistamines. Prolonged use of the drug is not advisable without frequent medical supervision. Approximately 20 to 50 per cent of the patients taking antihistaminics experience side effects. The side effects are unpredictable, and usually occur the first few days after the administration of the drug. The reactions subside or disappear after cessation of the drug. Long acting antihistamines are less toxic because they are administered before retiring, and the dosage is generally smaller. For example, where Chlor-Trimeton is given in a dose of 2 to 4 mg. practically no side reactions are encountered.

The most common side reaction is drowsiness and is usually due to the ingestion of Benadryl, Decapryn, and Phenergan. Other untoward reactions encountered are dizziness, restlessness, headache, insomnia, anorexia, nausea, vomiting, abdominal cramps, dryness of the mouth, and constipation. In some patients frequency of urination, weakness, fatigue, confusion, excitability, loss of judgment, palpitation, and precordial pain may be seen. Other less common toxic symptoms are cutaneous lesions such as fixed drug eruption,[25] erythema multiforme-like eruption, pityriasis rosea-like,[26] maculopapular eruption,[24,26] toxic erythema,[27] urticaria,[28,30] and allergic eczematoid dermatitis[31,32] (contact type). Other unusual systemic untoward effects that have been reported are respiratory distress, hypertension,[33] blood dyscrasias such as anemia,[34] agranulocytosis,[35-37] purpura,[27] and leukopenia. The local application of these drugs may produce a contact dermatitis, but cutaneous reactions from the oral use of antihistaminics are not common. Drugs with the benzene ring may produce agranulocytosis, and may aggravate the lesions in people sensitive to these drugs. If such an idiosyncrasy should appear, withdrawal of the medication is indicated. Pyribenzamine, Diatrine, Benadryl, and Thenylene have produced agranulocytosis. Drugs such as Chlor-Trimeton, Thephorin and Decapryn do not have a nitrogen molecule and are probably safer if administration over a long period of time is necessary. There has been no report of agranulocytosis produced by the latter drugs. Deaths have been reported in children as a result of convulsions. Even one dose may precipitate epileptic seizures, or may increase their frequency. Churchill and Gammon[38] observed epileptic seizures following the administration of antihistaminic agents in doses even smaller than those generally employed clinically. Undesirable reactions must be weighed against the severity of symptoms for which the drug is given. Frequently the patient complains that the treatment is worse than the disease. Drowsiness and dizziness may lead to serious error in business or in failure of performance in operating an automobile or machine in industry. One should not hesitate to discontinue the drug. Over dosage may produce confusion and excitement. In severe cases it may produce acute toxic psychosis, hallucinations, and delusions. Where insomnia or itching is present, the use of Pyribenzamine or Pyrrolazote during the day and Benadryl, Decapryn, or Phenergan at night is very effective and may circumvent reactions.

Summary

Antihistamines have given prompt relief of symptoms in many pruritic dermatoses. They are palliative in nature, but are a valuable addition to the dermatologic armamentarium. Present antihistaminic drugs are not effective in all allergic manifestations and are not universally useful in any particular syndrome. The best symptomatic relief has been seen in allergic rhinitis, urticaria, serum sickness, and hay fever. They do not eradicate allergic manifestation and should not be considered cures for these diseases. They may in fact aggravate the lesions in some cases. Prolonged use of antihistamines may result in the development of tolerance to the drug. The indiscriminate use of the drug is to be avoided as such use may often prolong the disease. They do not alter the course of the common cold. They produce untoward side effects in some cases, namely drowsiness, dizziness, restlessness, nausea, vomiting, headache, and blood dyscrasias such as agranulocytosis, anemia, and leukopenia. Cutaneous manifestations from antihistaminics are extremly rare though possible. Caution and patience must be exercised in evaluating the response to any drug. No two people respond the same. Some patients respond better to one type of antihistaminic than to

others. If a given antihistamine fails to help or gives untoward side effects, another member of a different group should be substituted. The sale of these drugs should not be permitted without a prescription, and the prescription should not be refillable, as medical supervision is absolutely necessary to determine if the antihistaminic is helpful, and to avoid dangerous untoward reactions.

---

425 East Wisconsin Avenue.

REFERENCES

1. Fourneau, E., and Bovet, D.: Recherches sur l'action sympathicolytique d'un nouveau dérivé du dioxane, Arch. internat. de pharmacodyn. et de thérap. 46:178–191 (Oct. 15) 1933.
2. Bovet, D., and Staub, A. M.: Action protectrice des ethers phenoliques au cours de l'intoxication histaminique, Compt. rend. Soc. de biol. 124:547–549, 1937.
3. Halpern, B. N.: Les antihistaminiques de synthése. Essais de chimiothérapie des états allergiques, Arch. internat. de pharmacodyn, et de thérap 68:399–408 (Dec. 31) 1942.
4. Loew, E. R., Kaiser, M. E., and Moore, V.: Synthetic benzhydryl alkamine ethers effective in preventing fatal experimental asthma in guinea pigs exposed to atomized histamine, J. Pharmacol. & Exper. Therap. 83:120–129 (Feb.) 1945.
5. Mayer, R. L., Huttrer, C. P., and Scholz, C. R.: Antihistaminic and antianaphylactic activity of some apyridinoethylenediamines, Science 102: 93–94 (July 27) 1945.
6. Feinberg, S. M.: Histamine and antihistaminic agents; their experimental and therapeutic status, J.A.M.A. 132:702–713 (Nov. 23) 1946.
7. Sherman, W. B.: The uses and abuses of antihistaminic drugs, Bull. New York Acad. Med. 27: 309–324 (May) 1951.
8. Perlman, E.: Antihistaminic agents, studies of their metabolism by means of quantitative analytical methods, Bull. New York Acad. Med. 26 565–566 (Aug.) 1950.
9. Shaffer, L. W., Carrick, L., and Zackheim, H. S.: Use of benadryl for urticaria and related dermatoses, Arch. Dermat. & Syph. 52:243–245 (Oct.) 1945.
10. Curtis, A. C., and Owens, B. B.: Beta dimethylaminoethyl benzhydryl ether hydrochloride (benadryl) in treatment of urticaria, Arch. Dermat. & Syph. 52:239–242 (Oct.) 1945.
11. Spain, W. C., and Pflum, F. A.: An evaluation of the present status of antihistaminic substances, New York State J. Med. 48:2272–2275 (Oct. 15) 1948.
12. Peshkin, M. M., Rapaport, H. G., and Grosberg, S.: Phenergan: a clinical evaluation based on a study of 193 allergic patients. Ann. Allergy 9: 727–740 (Nov.-Dec.) 1951.
13. Seidmon, E. E. P.: Treatment of hypersensitive rhinitis and other allergic diseases with chlortrimeton, Ann. Allergy 9:387–389 (May–June) 1951.
14. Wright, W. A.: The antihistamine chlor-trimeton, Medical Times 78:466–469 (Oct.) 1950.
15. Waldriff, G. A., Davis, J., and Lewis, G. M.: Antihistaminic drugs in dermatologic therapy, Arch. Dermat. & Syph. 61:361–378 (March) 1950.
16. Halpern, B. N.: Recent advances in the domain of the anti-histamine substances; the phenothiazine derivatives, Bull. New York Acad. Med. 25:-323–330 (May) 1949.
17. Bereston, E. S.: Evaluation of histadyl cream, J. Invest. Dermat. 12.157–158 (March) 1949.
18. Ellis, F. A., and Bundick, W. R.: An appraisal of the value of the topical use of the antihistamines. Presented at A.M.A. Meeting, Dermat. & Syph. Scientific Section, June 10, 1952, Chicago, Illinois.
19. Lynch, F. W.: Benadryl in dermatologic therapy, Arch. Dermat. & Syph. 55:101–108 (Jan.) 1950.
20. Foster, P. D.: Antihistaminic drugs in dermatology, California Med. 73:413–420 (Nov.) 1950.
21. Notier, V. A., and Roth, G. M.: Treatment of hypersensitiveness to cold with benadryl; report of a case, Proc. Staff Meet., Mayo Clin. 21:170–175 (April 17) 1946.
22. Osborne, E. D., Jordan, J. W., and Rausch, N. G.: Clinical use of a new antihistaminic compound (pyribenzamine) in certain cutaneous disorders, Arch. Dermat. & Syph. 55:309–321 (March) 1947.
23. Andrews, G. C.: Abstract of Discussion of Osborne's Case, ibid. 55:319–320 (March) 1947.
24. Frankfeldt, F. M.: Pyribenzamine, its role in the treatment of pruritus ani, Am. J. Surg. 75:307-312 (Feb.) 1948.
25. Barrock, J. J.: Drug eruptions due to antihistaminics, Wisconsin M. J. 50:156–158 (Feb.) 1951.
26. Epstein, E.: Dermatitis occurring during therapy with tripelennamine hydrochloride ("pyribenzamine hydrochloride"), J.A.M.A. 134:782 (June 28) 1947.
27. Brown, W. M. C., and Hunter, R. B.: Antihistamine drugs and radiation sickness, Brit. M. J. 2:984 (Dec. 4) 1948.
28. London, I. D., and Moody, M., Jr.: Acute urticaria following pyribenzamine therapy, a case report, J. Invest. Dermat. 13:217–219 (Oct.) 1949.
29. Heise, H. A.: Personal communication to the author.
30. Glesen, C. P.: Personal communication to the author.
31. Mosko, M. M., and Peterson, W. L.: Sensitization to antistine, J. Invest. Dermat. 14:1–2 (Jan.) 1950
32. Strauss, M. J.: Eczematous contact-type allergy to pyribenzamine, J. Invest. Dermat. 11:155 (Sept.) 1948
33. Gelfand, H. H.: Hypertension following benadryl, in "Queries and Minor Notes," J.A.M.A. 134: 1278 (Aug. 9) 1947.
34. Crumbley, J. J.: Anemia following use of antihistaminic drugs, J.A.M.A. 143:726–728 (June 24) 1950.
35. Blanton, W. B., and Owens, M. E. B.: Granulocytopenia due probably to "pyribenzamine," J.A.M.A. 134:454–455 (May 31) 1947.
36. Cahan, A. M., Meilman, E., and Jacobson, B. M.: Agranulocytosis following pyribenzamine, New England J. Med. 241:865–867 (Dec. 1) 1949.
37. Drake, T. G.: Agranulocytosis during therapy with the antihistaminic agent methaphenilene (diatrin), J.A.M.A. 142.477–478 (Feb. 18) 1950.
38. Churchill, J. A., and Gammon, G. D.: The effect of antihistaminic drugs on convulsive seizures, J.A.M.A. 141;18–21 (Sept. 3) 1949.

Transverse Presentation*

By JOHN E. SINSKY, M. D.
Milwaukee

RECENTLY a number of papers have been published reviewing transverse lie or transverse presentation. In this condition infant mortality is high, and maternal deaths occur not infrequently. For this reason, such cases at St. Joseph's Hospital during the past five years were reviewed.

Transverse presentation is the condition in which the longitudinal axis of the fetus lies at right angles or obliquely to the longitudinal axis of the mother. The scapula is the point used to designate the position of the fetus.

The most important etiologic factors are usually given as multiparity (with relaxed uterus and abdominal walls), contracted pelvic inlet, and placenta previa. Stevenson recently stressed the importance of fundal implant of the placenta as well as placenta previa as etiologic factors. Other causes are pelvic tumors, full bladder and rectum, pendulous abdomen, polyhydramnios, malformed uterus, multiple pregnancy, fetal anomalies, and an excessively small or large fetus.

In most instances the diagnosis can be made by physical findings. On inspection the abdomen is enlarged transversely. Palpation reveals the fetal head in the right or left flank, and there is an absence of fetal parts immediately above the pubic symphysis. Rectal and especially vaginal examination reveal either the absence of any palpable fetal parts or abnormal presenting parts, such as a prolapsed extremity, shoulder, or rib cage. X-ray will confirm the above findings.

The prognosis from the fetal standpoint is poor, particularly in the cases delivered vaginally. The fetal mortality is largely due to prolapsed cord, birth trauma, and anoxia from uterine tetany. Early rupture of membranes materially adds to the fetal hazard. Concerning maternal mortality, the results are better with cesarean section because accidents such as lacerations and ruptured uterus may accompany version and extraction. However, even in good hands the maternal results must be relatively poor because of the occurrence in older women, the frequent coexistence of placenta previa, and the frequent necessity of operative intervention.

No definite rules can be made to cover the management of all cases of transverse lie. If the diagnosis is made late in pregnancy or early in labor, external cephalic version can be attempted. In many instances this is unsuccessful. If the diagnosis is made in a primipara early in labor, the treatment of choice is cesarean section. Version and extraction should be reserved for those cases in which the diagnosis is made late in labor and in which the conditions necessary for its performance obtain. An occasional case will terminate by spontaneous delivery or by spontaneous evolution, resulting in a high fetal mortality. The neglected transverse presentation with a live fetus, and in most instances with a dead fetus, is best handled by cesarean section. Some cases with a dead fetus may be delivered vaginally with decapitation, but version and extraction is a dangerous procedure because of the hazard of ruptured uterus accompanying the thinned-out lower segment. Available blood, antibiotics, and oxygen are valuable adjuncts in the treatment.

During the years 1947 to 1951 there were 20,033 deliveries at St. Joseph's Hospital, and, of these, 34 were transverse presentations. The incidence was 1:588. (Table 1) Of these cases, 27 were considered, the remainder being cases of multiple pregnancy or infants less than 1,500 Gm. in weight.

In this series, 22 of the patients were multiparas, but none was a grand multipara. Placenta previa could be ascribed as the cause in 12 of the cases. The fetal size did not appear to be of any great significance in the etiology, the average weight being 2,932 Gm. (Table 2)

TABLE 1—*Transverse Presentation (1947–1951)*

No. of cases	34
No. of deliveries	20,033
Incidence	1:588
No. of cases excluding multiple pregnancy and infants under 1,500 Gm.	27

TABLE 2—*Etiologic Factors*

1. Placental site	
a. Placenta previa	12
b. Fundal region	3
c. Undetermined	12
2. Multiparity	22
3. Contracted inlet	4
4. Pelvic tumors	1
5. Malposition of uterus	1
6. Fetal size (av. 2,932 Gm.)	
a. 1,500–2,500 Gm.	5
b. 2,500–4,000 Gm.	18
c. Over 4,000 Gm.	2
d. Unknown	2

TABLE 3—*Maternal Analysis*

1. Age	
20 years or less	1
21–30 years	13
31 and over	13
2. Parity	
Para 0	5
1	8
2	7
3	4
4 and over	3
3. Maternal disease	
Preeclampsia	2
4. Morbidity	2
5. Mortality	0

*Presented at the monthly staff meeting of St. Joseph's Hospital, Milwaukee, on January 31, 1952.

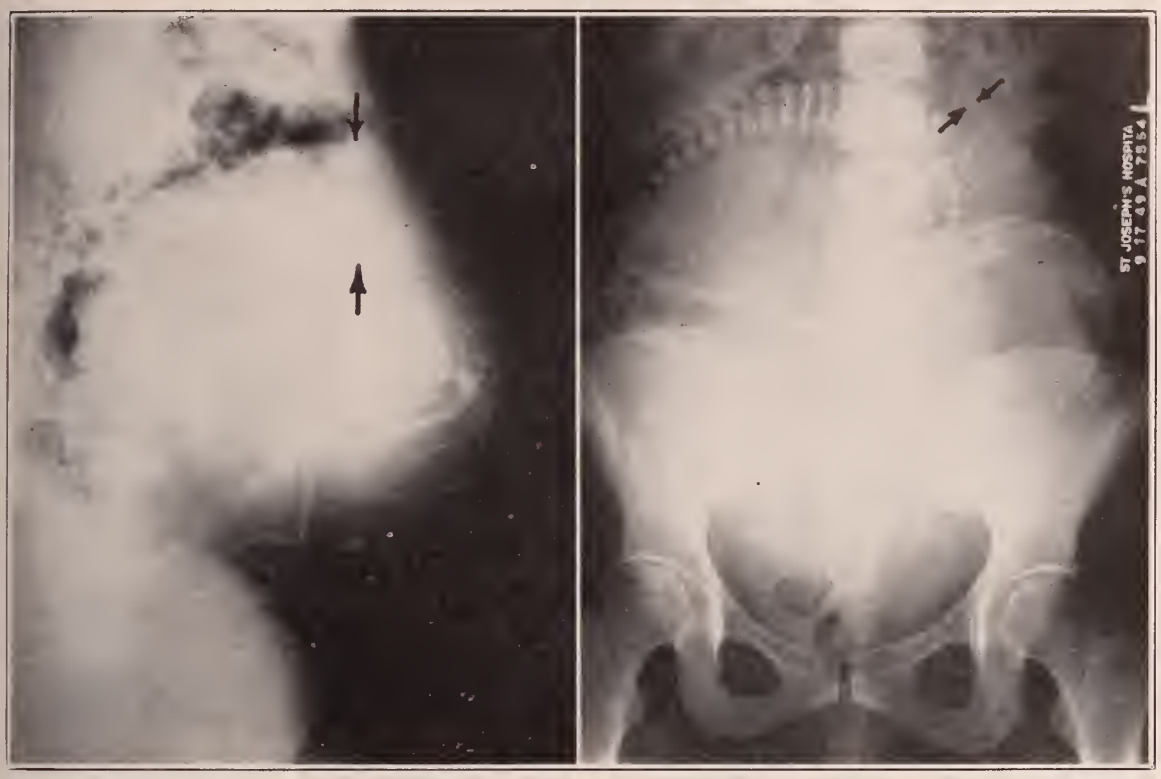


Fig. 1—(left) X-Ray demonstrating placenta in fundal region of uterus. (right) X-ray of another case showing thin uterine wall in fundal area not containing the placenta.

TABLE 4—*Vaginal Deliveries*

	Number	Per Cent
Cases	7	26.0
Fetal results		
Deaths		
Birth trauma	1	
Prolapse cord	1	
Anoxia (Placenta previa)	1	
Total	3	42.8
Maternal Results		
Morbidity	0	0
Mortality	0	0
Complications: 1 vesicovaginal fistula and lacerated cervix (same patient)		

TABLE 5—*Abdominal Deliveries*

	Number	Per Cent
Cases	20	74.0
Fetal results		
Deaths		
Erythroblastosis	1	5.0
Maternal results		
Morbidity	2	7.4
Mortality	0	0
Complications	0	0

No maternal mortalities were encountered in this group of cases. (Table 3) Comparing the vaginal and abdominal deliveries, 7, or 26 per cent, were delivered vaginally; and 20, or 74 per cent, were delivered by cesarean section. (Tables 4, 5) There were three fetal deaths in the 7 cases delivered by version and extraction. Excluding one of these deaths because of absent fetal heart tones on admission, the infant mortality was 28.5 per cent. Of the 20 cases delivered by cesarean section, there was one fetal death, this due to erythroblastosis, for a mortality rate of 5 per cent. The total fetal mortality rate was 14.8 per cent, and excluding the mentioned case, 11.1 per cent.

Spontaneous rupture of membranes prior to the onset of labor, suggesting the possibility of an abnormal presenting part, was noted in ten instances in this review.

The comparatively good results in this series can be attributed to a number of factors. The series is a recent one, and the majority of cases were terminated by cesarean section. Excellent premature infant care, early diagnosis, and the liberal use of oxygen, blood, and antibiotics when indicated are other factors.

Summary

1. Transverse presentation is briefly reviewed, and 27 cases are presented.

2. Version and extraction has a definite but limited place in the management of such cases.

3. The majority of cases are handled best by cesarean section.

335 West North Avenue.

REFERENCES

1. Greenhill, J. P., originally by DeLee, J. B.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951,

2. Eastman, N. J.: Williams Obstetrics, ed. 10, New York, Appleton, Century, Crofts, Inc., 1950.

3. Garber, E. C., Jr., and Ware, H. H., Jr.: Transverse presentation of fetus, Am. J. Obst. & Gynec. 61: 62–70 (Jan.) 1951.

4. Harris, B. A., Jr., and Epperson, J.W.W.: Analysis of 131 cases of transverse presentation, Am. J. Obst. & Gynec. 59:1105–1111 (May) 1950.

5. Johnson, C. M.: Transverse presentation of the fetus; an analysis of 186 consecutive cases, Am. J. Obst. & Gynec. 57 765–769 (April) 1949.

6. Montello, S. A.: Management of the transverse lie, Am. J. Obst. & Gynec. 61:1360–1365 (June) 1951.

7. Stevenson, C. S.: Transverse or oblique presentation of fetus in last 10 weeks of pregnancy; its causes, general nature, and treatment, Am. J. Obst. & Gynec. 58:432–446 (Sept.) 1949.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Monday	3:30 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

Proceedings of the Milwaukee Academy of Medicine, December 16, 1952

Differential Diagnostic Problems in Infectious Mononucleosis

By ISRAEL DAVIDSOHN, M. D.
Chicago, Ill.

INFECTIOUS mononucleosis is an acute infectious disease of the lymphoreticular tissues, with fever, generalized swelling of lymph nodes, characteristic changes in the white blood cells and in the blood serum, and leading, as a rule, to recovery within a few weeks. It occurs sporadically and in epidemics, in the latter form mostly among young individuals in schools and dormitories. There are not infrequently severe cases of the disease and complications which may endanger life.

The clinical picture can be fitted into four groups according to Tidy:[1]

(1) The form which most closely resembles glandular fever as described by Pfeiffer, with fever, rapid and visible swelling of cervical lymph nodes, and a short duration. The lymph nodes are frequently tender in this form of the disease.

(2) The disease, occurring in adolescents and young persons, with a longer course, less pronounced swelling of lymph nodes and, usually, milder fever.

(3) The third variety, which was studied particuarly thoroughly in Germany, with ulcerative and membranous lesions in the pharynx which are commonly invaded by the micro-organisms seen in Vincent's angina, is frequently difficult to distinguish from diphtheria. It is this form of the disease which the German writers called lymphocytic or monocytic angina. They made the mistake of assuming that it is a constitutional reaction to an infection in which one person reacts with an increase of lymphocytes, a second with an increase of monocytes, and a third with an increase of polymorphonuclear leukocytes. They placed the emphasis on the constitutional reaction of the host and not on the infectious agent.

(4) The last form has a long febrile course, somewhat resembling typhoid fever, frequently with a long period of prodromal manifestations, and with lymph nodes appearing late in the disease, sometimes two or three weeks after the onset of symptoms. The enlargement of lymph nodes in this form is not very striking.

This classification is useful, but it should be kept in mind that the disease is a single entity and that there are many transitions and modifications in the scheme as it is outlined.

Until recently, writers on the subject have been emphasizing the benign nature of the disease. During the last few years, a rather impressive number of fatal cases have been described so that the disease is not to be considered as absolutely benign as it has been. Nevertheless, the serious complications are still rare. Therefore, it seems justified to quote the old saying that infectious mononucleosis interests us not for what it is but for what it pretends to be. This statement is an expression of the fact that the disease imitates many other clinical entities.

The Clinical Picture of Infectious Mononucleosis

The onset of the disease is vague. There is an incubation period varying from 4 to 28 days. In the fully developed disease there is fever (varying from mild to 104 F. and occasionally going as high as 106 F.), chills, sweats, headache, dizziness, malaise, retro-orbital aching, irritability, and asthenia—all of varying severity. Cases without fever occur, especially in epidemics.

Lymph nodes usually become involved early in the disease. The cervical lymph nodes are the first to be enlarged, frequently beginning on one side and spreading to the other side and to other regions of the body. Their enlargement may appear simultaneously with the onset of fever, or it may precede or follow it. The enlargement appears rapidly, which is the probable explanation of the characteristic tenderness.

The tenderness should be looked for because it is frequently of help in the differential diagnosis. Occasionally, the tenderness of lymph nodes in the back of the neck is sufficiently pronounced to force the patient to hold the neck rigidly and invite the suspicion of meningitis. The enlarged lymph nodes may persist for a long time, sometimes in all regions, sometimes only in one location.

The most important feature of infectious mononucleosis is the frequency with which it is mistaken for other diseases. This is well illustrated in our own material. During the last 16 years we studied about 219 cases of infectious mononucleosis. Some of these were sent only for laboratory tests and complete clinical data were not available. Clinical data were known in 106 cases. In these cases, experienced clinicians made the correct diagnosis in 43 cases before the blood counts and serologic tests were available. In the remaining 63 cases, 26 different diagnoses were made. In addition, 23 other diagnoses were collected from the literature. The

diagnostic difficulties are not at all surprising when one considers the variety of clinical manifestations. The form which involves the pharynx with extensive membrane formation is the one which gives rise to differential diagnostic difficulties with diphtheria.

The pain in the upper abdomen is frequently due to a tender and rapidly enlarging spleen. In one of our cases the pain was so severe that an operation was prevented only by the laboratory report. Pain in the right lower abdomen has probably been responsible for the removal of appendixes. It is due to rapid enlargement of lymphatic tissue in the appendix and to swelling of mesenteric lymph nodes.

The headache is sometimes pronounced, particularly when retrobulbar. There may be marked prostration lasting for many weeks.

Various skin rashes have been described resembling those seen in exanthemata. Icterus is a rare complication, occurring most frequently in adults. The changes in the liver, to be described later, explain the jaundice.

Blood in Infectious Mononucleosis

The most important alterations are quantitative and qualitative changes in lymphocytes, which can be classified under the following headings:

(1) Hyperplasia: An increase in the number of the cells ranging from 15,000 to 25,000 in most instances, although rises to 40,000 in adults, and to 70,000 in infants, have been reported.

(2) Hypertrophy: In most instances the lymphocytes are larger than the normal cells. Striking differences in size are frequent (lymphocytic anisocytosis).

(3) Nuclear Pleomorphism: There is loss of the normal oval or round shape with formation of irregular lobes (lymphocytic poikilocytosis). The chromatin is clumped, dense, and lacks the differentiation seen in normal lymphocytes. In some cells the nuclei resemble those of monocytes (monocytoid deviation). Occasional nuclei may show anaplastic changes with prominent nucleoli. Division of nuclei and mitotic figures may be present.

(4) Cytoplasmic Basophilia: The cytoplasm is abundant, usually deeply basophilic, and sometimes vacuolated (vacuolar degeneration).

The mononucleosis persists for weeks and, in some instances, even for months. In occasional cases, abnormal lymphocytes may be found years after the illness.

The morphologic changes in the blood are not pathognomonic for infectious mononucleosis because similar cells may be found in other conditions.

Liver Function Tests

We found an elevated icterus index, in most instances in the range of so-called latent jaundice, in more than 50 per cent of cases. The cephalin flocculation test is frequently, and the thymol turbidity test is uniformly, positive. Cholesterol and cholesterol esters are within normal limits. This is in keeping with recent reports on liver function studies in infectious mononucleosis by other writers.

The Serologic Diagnosis of Infectious Mononucleosis

There are two serologic tests for infectious mononucleosis. The so-called presumptive test, also known as the heterophile antibody or Paul and Bunnell test,[2] and the differential test.[3-6]

The presumptive test is based on the presence of antisheep agglutinins in titers higher than normally found. These agglutinins are called heterophilic because they owe their origin to an antigen different from sheep red cells, and the test is therefore known also as heterophilic antibody test or the Paul and Bunnell test.

The technic of the presumptive test is very simple. It is presented in outline form in table 1. Natural antisheep agglutinins are present in about 93 per cent of persons. The titers vary from 1:7 to 1:112. The range, in close to 90 per cent, is from 1:7 to 1:28; the titers 1:56 and 1:112 are rarely present. In those given horse serum, titers of a very high order may be found.

The heterophilic antibody test or the Paul and Bunnell test has definite limitations. It is purely quantitative because antisheep agglutinins are present also in persons free of infectious mononucleosis, in normal individuals, and in persons suffering from a variety of diseases. The only thing that is different in infectious mononucleosis is the elevated titer. On the other hand, many patients with infectious mononucleosis have titers lower than the highest normally seen (1:112).

TABLE 1—*The Presumptive Test for Infectious Mononucleosis.*

Technic

The physician: Obtain 5–10 cc. of blood under aseptic precautions. Send to the laboratory.

The laboratory:

(1) Reagents:
- (a) Serum inactivated for 30 minutes at 56° C.
- (b) 2% suspension of sheep red cells.

(2) Procedure:
To 0.25 cc. of increasing dilutions of serum, add 0.1 cc. of the sheep cell suspension.

(3) Reading of results:
LET STAND AT ROOM TEMPERATURE FOR 2 HOURS OR LESS. If in a hurry, read test after 15 minutes, and if negative, repeat reading at intervals. In many instances positive findings can be obtained after these short periods of time. The titer is the reciprocal value of the highest serum dilution still showing agglutination.

TABLE 2—*Interpretation of the Presumptive Test for Infectious Mononucleosis.*

In the presence of clinical and/or hematologic findings suggestive of infectious mononucleosis, titers of 1:224 or higher in the presumptive test confirm the diagnosis of infectious mononucleosis. If the titer of the presumptive test is less than 1:224 in the presence of clinical and/or hematologic findings suggestive of infectious mononucleosis; or, if the titer of the presumptive test is 1:224 or higher in the absence of clinical and hematologic findings suggestive of infectious mononucleosis; or, if the patient has a history of a recent horse serum injection, the result of the presumptive test should be checked by the differential test.

TABLE 3—*Principle of the Differential Test for Infectious Mononucleosis.*

The heterophilic antibodies (antisheep agglutinins) in infectious mononucleosis are not of the Forssman type. They are not absorbed by suspensions of quinea-pig kidney but are readily and completely absorbed by beef red cells. The heterophilic antibodies in normal persons, in horse serum sensitization, and in a variety of other conditions, are of the Forssman type and are readily and completely absorbed by suspensions of guinea-pig kidney. In horse serum sensitization, absorption with beef cells removes the sheep agglutinins readily and completely, whereas in normal persons and in patients with diseases other than infectious mononucleosis or horse serum sensitization, sheep agglutinins are frequently removed only partially by the beef cell antigen.

TABLE 4—*Interpretation of Results of the Differential Test for Infectious Mononucleosis.*

In no instance of infectious mononucleosis, in our experience, were agglutinins for sheep red cells removed completely by guinea-pig kidney. Maximum absorption was 87.5 per cent, which is equivalent to a three-tube-drop of the titer. This was seen in only 10 per cent of the tests.

If all or almost all (more than 90 per cent) of the agglutinins have been removed in the differential test, infectious mononucleosis is excluded.

In our experience, infectious mononucleosis is the only disease in which antisheep agglutinins show the following behavior:

(1) At least 12 per cent of the original titer of antisheep agglutinins remains after absorption with guinea-pig kidney;

(2) The antisheep agglutinins are completely removed after absorption with beef red cells.

Examples

	Titer of Presumptive Test	Differential Test After Absorption With Guinea Pig Kidney	Differential Test After Absorption With Beef Red Cells	Result
(a)	1:448	1:224	1:224	NEGATIVE for infectious mononucleosis
(b)	1:448	1:224	0	POSITIVE for infectious mononucleosis
(c)	1:224	0	1:112	NEGATIVE for infectious mononucleosis

The interpretation of results of the presumptive test is recorded in table 2. The principle of the differential test is described in table 3. The interpretation of the differential test is summarized in table 4. Almost 16 per cent of patients in whom the presumptive test (Paul and Bunnell) was done early in the disease showed titers less than 1:112, a non-diagnostic titer. In follow-up tests, from 3 to 18 weeks after onset of symptoms, 38 per cent had titers of 1:112 or less. In other words, in 56 per cent of cases the Paul and Bunnell test was not diagnostic. The specific serologic diagnosis was made possible only through the differential test.

Pathologic Lesions in Infectious Mononucleosis

Recent biopsy and autopsy studies have increased our knowledge of pathologic tissue changes in infectious mononucleosis. Diffuse hyperplasia of lymphoreticular tissues has been noted in many organs such as lymph nodes, spleen, liver, etc. Similar and diffuse histopathologic changes have been described involving many organs, including those mentioned and also the lungs, the central nervous tissues, etc.

Mt. Sinai Hospital.

REFERENCES

1. Tidy, H.: Infectious Mononucleosis, George R. Minot Symposium on Hematology, Edited by Dameshek and Taylor. New York, Grune and Stratton, 1949, pp. 607–703.
2. Paul, J. R., and Bunnell, W. W.: Presence of heterophile antibodies in infectious mononucleosis, Am. J. M. Sc. 183:90–104 (Jan.) 1932.
3. Davidsohn, I.: Heterophile antibodies in serum sickness, J. Immunol. 16 259–273 (March) 1929.
4. Davidsohn, I., and Walker, P. H.: Nature of heterophilic antibodies in infectious mononucleosis, Am J. Clin. Path. 5:455–465 (Nov.) 1935.
5. Davidsohn, I.: Test for infectious mononucleosis, Am. J. Clin. Path., Tech. Supp. 2:56–60 (March) 1938.
6. Davidsohn, I., Stern, K., and Kashiwagi, C.: The differential test for infectious mononucleosis, Am. J. Clin. Path. 21 1101–1113 (Dec.) 1951.

WISCONSIN TRUDEAU SOCIETY ANNUAL MEETING

PRELIMINARY PROGRAM

Hotel Schroeder, Milwaukee, Saturday, April 25, 1953

9:00 Registration

9:30 Cardio–Pulmonary Function Studies in Pulmonary Emphysema
Ned Geo. Maxwell, M. D.
Timothy R. Murphy, M. D.
Veterans Administration Hospital, Wood

10:15 Histoplasmosis
Helen A. Dickie, M. D.
Wisconsin General Hospital, Madison

10:45 Blastomycosis
W. D. Sutliff, M. D.
Kennedy Veterans Administration Hospital, Memphis, Tenn.

11:30 Discussion

12:00 Lunch

2:00 Observations on Over 100 Patients Having Pulmonary Resection for Pulmonary Tuberculosis After Four or More Months of Streptomycin and PAS
Benjamin G. Narodick, M. D.
Muirdale Sanatorium, Milwaukee

2:30 Insonicotinic Acid Hydrazide Therapy in Chronic Pulmonary Tuberculosis
John K. Shumate, M. D.
Lake View Sanatorium, Madison

3:00 One Year of Experience with Isoniazid at Muirdale Sanatorium
Richard P. Jahn, M. D.
Muirdale Sanatorium, Milwaukee

3:40 Discussion

Home Nursing For the Cardiac Patient

As It Looks to Your State Board of Health

AS MORE intensive studies are made of the increased incidence and mortality of cardiac disease, the more apparent is the need for its prevention and control. We are concerned with reports that approximately 9,000,000 people in our country have cardiac disease; that in one year its various forms claimed the lives of 54 per cent of adults who died after age 65, and 11 per cent of children who died between the ages of 5 and 15. These deaths were three times as great as those due to cancer, five times the deaths by accidents, and fourteen times those with tuberculosis.*

This accumulation of facts causes cardiac disease to be ranked as public health's number one problem. The program of public health departments is directed primarily toward prevention. The public health nurse has an important contribution to make in this activity through public education and through her visits in the homes. The amount of bedside care given by public health nurses varies considerably, with the average county nurse doing very little in comparison to the visiting nurse who devotes a large share of her time to it.

In her round of activities, which includes assistance in physical examinations and chest x-ray programs, the public health nurse refers to the family physician children and adults who have suspicious symptoms of cardiac impairment. In the schools the teachers are advised to watch for excessive fatigue, evidences of fever and sore throat, leg cramps, restlessness, irritability, pallor, or cyanosis. Likewise in her advice to community groups, the nurse emphasizes the need to protect children from virus infections and cautions parents against sending them back to school too soon after a serious illness. Good nutrition, as well as weight reduction and avoidance of excessive nervous strain and overexertion, are other points reiterated in her health teaching.

When patients are referred to her for home nursing, the public health nurse arranges for conferences with the physician and hospital nurses so that care may be continued without interruption. In this way she gains an understanding of the patient's previous condition and emotional needs, whether his symptoms are resulting from hypertension, arteriosclerosis, congenital heart defects, rheumatic fever, or from other diseases which leave their effects on the heart.

The physician's orders for treatment are carried out and demonstrated to the member of the household who is to assume responsibility in the nurse's absence. Although bed rest may not be prolonged, it is important that the helper be taught care of the skin and proper methods of turning the patient in bed. Measures for supporting various parts of the body are suggested and improvised, including an overbed table for the patient with respiratory distress. The helper is taught to take temperature, pulse, and respiration, and to watch for any change in the color of lips and nail beds.

The nurse also lends valuable assistance in planning the menus when the physician has ordered a diet for weight reduction. Besides selecting foods of low caloric value, she offers suggestions that will provide a well balanced diet. In addition, she helps the family in adjusting to the patient's condition, in keeping tension and disturbance at a minimum, and in reducing the patient's anxiety, factors which she knows to be essential in aiding the patient's recovery.

When the physician has given orders for his patient with cardiac failure, special assistance is given in the selection of foods of low sodium content, as well as in the daily weighing of the patient, watching for possible reactions from drugs and reporting to the physician all signs of the patient's progress.

When the acute symptoms subside and the patient is allowed up a little more each day in a chair or to the commode, directions are given in assisting the patient out of bed without undue strain on the helper. At this time, the patient's mental outlook is usually improved, and we find increased cooperation on his part resulting in better physical response to treatment.

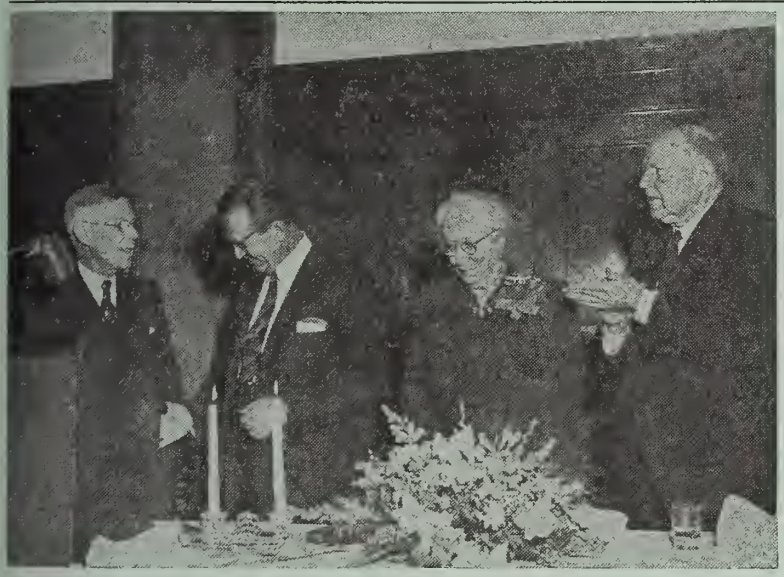
It calls for patience and ingenuity by members of the family, and by the nurse herself, in caring for the patient with a long-term illness and in giving him reassurance as he progresses to additional activity. He must likewise be cautioned against over-doing if shortness of breath and signs of fatigue reappear. During the entire convalescent period the nurse has an opportunity to direct the patient's thoughts toward his gradual return to a normal life. Plans for resuming work may be discussed, and, when advised by the physician, referrals are made to the community agencies concerned with the patient's economic welfare and rehabilitation. These workers will assist him in obtaining some type of occupational therapy and eventual, though limited, employment.—JANET JENNINGS, *R. N., Director, Bureau of Public Health Nursing.*

---

*From Report of National Conference of Cardio-Vascular Diseases, American Heart Association and National Heart Institute, April 1950.

THE MEDICAL FORUM

DR. STOVALL SEES BRIGHT FUTURE FOR PUBLIC HEALTH



CONGRATULATIONS are received by Dr. W. D. Stovall, left, director of the State Laboratory of Hygiene, from Dr. J. C. Griffith, president of the State Medical Society, at the testimonial dinner given by the society for Dr. Stovall the night of the dedication of the new building. Also pictured are Mrs. Stovall and Dr. S. E. Gavin, Fond du Lac, president of the State Board of Health.

Madison, March. 2—The future of public health in Wisconsin was never brighter than it is today, according to Dr. W. D. Stovall, director of the State Laboratory of Hygiene, who spoke to an assembly of about 85 doctors, state officials and lawmakers gathered at a testimonial dinner in his honor at the Park hotel February 28.

The dinner, sponsored by the State Medical Society, climaxed the formal opening day of the new State Laboratory of Hygiene on the University of Wisconsin campus. Dr. J. C. Griffith, Milwaukee, president of the society, presided.

Recalls Epidemics

Dr. Stovall reminisced about outbreaks of typhoid and diphtheria which he helped to combat in his earlier days in the Wisconsin field. These diseases are nearly eradicated now by the inroads of science. He also spoke of epidemics of cholera, yellow fever and malaria which have been successfully fought in the past. He hopes to see tuberculosis and syphilis similarly undermined in the next few years, but, he said "they won't really be licked until we have knocked out the last carrier."

Laboratory science, Dr. Stovall stated, first came forward with the concept of the disease carrier or outwardly healthy person who transmits disease germs. It is one of the important functions of laboratory science to immunize such carriers. Another function is to isolate cases of communicable disease such as tuberculosis and venereal disease. He pointed with pride to the reduction in the TB death rate which has dropped from 103 per 100,000 population to 9 per 100,000 since 1908.

"Our tuberculosis death rate is still too high," said Dr. Stovall, stating that there were 350 TB deaths during the past year. But he feels we should be encouraged when we remember that there were 500 typhoid deaths in 1910 while nowadays a case of typhoid is a rarity.

The third great function of

(Continued on page 198)

MD's GAVE $3,150,000 IN SUPPORT OF MEDICAL EDUCATION DURING '52

Chicago, Feb. 10.—Nearly 37,000 physicians in the United States gave more than $3,150,000 in direct support of medical education during 1952, according to Dr. Donald G. Anderson, Chicago, secretary of the AMA Council on Medical Education and Hospitals.

Wisconsin's two medical schools received $72,407 of this money. Contributions from Wisconsin physicians came to $2,155.

The total quoted by Dr. Anderson did not include large amounts given for buildings, endowments, scholarships, research and other special purposes.

Of this total, the American Medical Education Foundation raised $906,553, an increase of more than 20 per cent over 1951. This total represents more than 7,000 contributions, as compared to approximately 1,800 in 1951.

Dr. Anderson also stated that the American Medical Education Foundation was beginning its 1953 campaign with a third gift of $500,000 from the AMA. A.M.E.F.'s goal for 1953 is set at $2,000,000.

Dr. Anderson, addressing the 49th annual Congress on Medical Education and Licensure in Chicago, said that reports from 76 of the country's 79 medical schools showed that more than 29,000 doctors had contributed another $2,258,534 directly to the schools' teaching budgets.

"The results should be considered evidence that the medical profession has made a real start toward helping relieve some of the financial pressure on medical schools," Dr. Anderson said. "More important, these figures should help to convince industry and business, when we ask them for more support, that we are also making a real effort at self-help."

M. D.'S URGED TO CONTINUE PROMOTING "YOUR DOCTOR"

Madison, Feb. 24.—The AMA's 15-minute public relations film, "Your Doctor," is now available in 16 mm. prints for showing at schools, industrial plants, civic groups and the like.

It has been viewed by more than twenty million theater-goers during the past year and has proved to be one of the most valuable public relations tools ever used by county and state medical societies.

Physicians are urged to continue keeping this film before the public. They and their auxiliaries can help by suggesting showings at all organizations to which they and their friends belong, and by continuing to urge theaters to add "Your Doctor" to their regular programs.

The 16 mm. version may be booked through the State Medical Society which owns a print and can secure others through the AMA. Bookings may be made directly with the State Medical Society and the only charge to the organization requesting loan of the print will be for postage and insurance.

In addition, county societies and local film libraries may secure prints at $70 each. The presentation of a print to a local library would be a fine public relations gesture on the part of any society, for it will be used again and again in health and civics classes.

If the film has not been shown at your local theater, a representative of your society or auxiliary should call upon the theater manager and ask him to display it, offering society cooperation in publicizing it.

What You Can Do to Assist Promotion of PR Film "Your Doctor"

Here are some of the things physicians and their wives can do to promote 16 mm. showings of "Your Doctor."

1. Distribute a two-color leaflet (Promotional Aid A) to groups in your community.
2. Secure mats (Promotional Aid C) to be used in printed publicity material and newspaper advertising.
3. Secure a larger mat (Promotional Aid D) which will reproduce a larger illustration especially suitable for post card announcements.
4. Request the use of a set of still photographs from "Your Doctor" (Promotional Aid E) which can be used to illustrate newspaper stories. These are also useful for window displays and posters.

All of these materials may be ordered through the State Medical Society, no charge.

Groups suggested as possible audiences for the film include schools, industrial plants, civic clubs, veterans groups, P.T.A.'s, women's clubs, church groups, 4–H Clubs, etc.

Wisconsin, Marquette Medical Schools Get Bequests from Trust

Milwaukee, Jan. 6.—Gifts of $10,000 each to the medical schools of the University of Wisconsin and Marquette University have been presented by trustees of the Kurtis R. Froedtert Memorial Trust.

Dr. William S. Middleton, Wisconsin medical school dean, said the money would be used for research in heart and blood vessel diseases, as was a previous Froedtert grant.

In accepting the Marquette gift, Dr. John S. Hirschboeck, medical dean, said that it will be used to establish the Kurtis R. Froedtert professorship in the school's department of surgery.

471 MDs, 258 Dentists In March Draft Quota

Washington, D. C., Feb. 8.—The Defense Department has called for a draft of 471 physicians and 258 dentists in March. Seven physicians and six dentists constitute Wisconsin's quota.

Of this total, 271 doctors and 213 dentists will be for the Army and the remainder for the Air Force.

The new call brings the number of doctors requested since July, 1951 to 4,246. Requests for dentists over the same period number 2,181.

Propose Broad Study of Social Security System

Washington, D. C., Feb. 24.—A broad study of the whole Social Security picture is proposed by House Ways and Means Committee Chairman Daniel A. Reed (R., N. Y.), who has appointed a subcommittee for the purpose.

This announcement is expected to interest all citizens who are concerned with the hodge-podge development of the present Social Security system.

If the findings of the study should result in a revision of the system to a pay-as-you-go plan, it is estimated that 10,000 fewer employees might be necessary to the Social Security administration.

Members of the subcommittee are Representatives Carl T. Curtis (R., Neb.), chairman; Angier L. Goodwin (R., Mass.); Howard H. Baker (R., Tenn.); Thomas B. Curtis (R., Mo.); Jere Cooper (D., Tenn.); John D. Dingell (D., Mich.) and Wilbur D. Mills (D., Ark.)

"Science vs. Chiropractic" Is Recommended Reading

Chicago, Feb. 10.—A new pamphlet, "Science vs. Chiropractic," is now being distributed by the Public Affairs Committee, Inc., New York. It is recommended reading for those who are interested in the cultist problem.

Copies of this pamphlet may be obtained by writing to the State Medical Society.

The article outlines the conflict between the theories behind chiropractic and the findings of modern science as established by experimentation and verified by medical practice.

It is factual throughout. It discusses the advantages and disadvantages of licensing chiropractors, but concludes that whether chiropractors are "licensed or practicing against the law, uninformed people will continue to patronize them just as they do bookmakers or fortune tellers, and for the same reason; they do not realize that the odds are all against them."

NEW STATE LABORATORY OF HYGIENE DEDICATED

Dr. Leonard A. Scheele Principal Speaker at Rites in New Building

Madison, March 2.—The new State Laboratory of Hygiene was formally dedicated at an afternoon ceremony which took place in the auditorium of the building February 28th.

The State Medical Society, the University of Wisconsin and the State Board of Health joined with the surgeon general of the United States Public Health Service, Dr. Leonard A. Scheele, in the ceremonies. Dr. C. N. Neupert, Wisconsin's chief health officer, presided, and the speakers in addition to Dr. Scheele included A. Matt Werner, Sheboygan, president of the university board of regents; President E. B. Fred of the university; Dean William S. Middleton of the university medical school and Dr. J. C. Griffith of Milwaukee, president of the State Medical Society.

Dr. Scheele expressed approval of the laboratory being located on the university campus, saying that laboratories of this type thrive best in an atmosphere of research and teaching.

"Wisconsin is known far and wide as the home of people who are not afraid to have new ideas or to put those ideas into practice in discharging their responsibilities as citizens," said Dr. Scheele.

"This great university with its outstanding medical school and hospital is one of those new ideas, and this laboratory and the public health program it serves are also Wisconsin ideas in practice.

"I wonder how many Wisconsin citizens realize that the staff of their State Laboratory performs, on the average, 17,000 tests per worker per year. This is considered a very heavy load."

Dr. Griffith Speaks

Dr. Griffith, speaking for the medical society, said that physicians have long recognized the importance of the laboratory "as a helpmate and ally in our fight against disease." He said there could be no doubt it has raised the level of health all over the state.

Dean Middleton warned that concerted attacks must be directed against the diseases that have taken the place of conquered killers, which, he reminded, are still in the background waiting to strike again if the public relaxes its vigilance.

Dr. Neupert praised the action of the legislature which provided Wisconsin's share of the funds and cited the leadership of former Governor Oscar Rennebohm in the matter.

Guests at the dedication ceremony, who were limited in number to the auditorium's seating capacity of 85, were taken on a tour of the building afterward. An open house for the purpose of showing the laboratory to other interested persons will be held at a later date.

The laboratory, which cost $1,600,000, is a four story structure equipped with the latest scientific apparatus for testing and research purposes. Its construction was financed 55% by the State of Wisconsin and 45% by the federal government.

DR. LEONARD A. SCHEELE, surgeon general of the United States Public Health Service, speaks at the dedication of the new State Laboratory of Hygiene. Left to right, Dr. W. S. Middleton, dean of the University of Wisconsin Medical school; President E. B. Fred of the University of Wisconsin; Dr. Scheele; A. Matt Werner, president of the university's Board of Regents; Dr. C. N. Neupert, state health officer and Dr. J. C. Griffith, president of the State Medical Society.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

215 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

NURSE RECRUITMENT GETS BOOST FROM AUXILIARY GROUP

Madison, Feb. 20.—One hundred per cent coverage of Wisconsin's secondary schools—that was the goal of the Nurse Recruitment Committee of the Woman's Auxiliary to the State Medical Society when they undertook to distribute brochures of information about nurses' training schools throughout the state.

And that is exactly what the committee has accomplished. The Wisconsin State Department of Nurses prepared the material and Mrs. Victor S. Falk, Jr. of Edgerton and her committee took it from there. Working on the committee with Mrs. Falk were Mrs. Albert G. Martin, Milwaukee, Mrs. Louis Fazen, Jr., Racine; Mrs. E. F. Cummings, Oshkosh; Mrs. Herbert Frank, Green Bay and Mrs. George H. Thomson, Beloit.

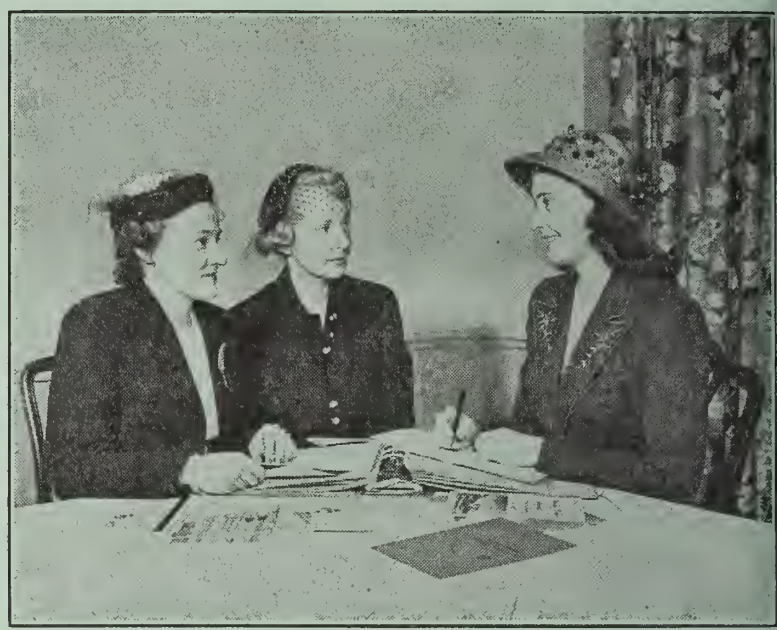
Filled Binders Last Summer

They began by working many days last summer at state department headquarters, placing the pamphlets from each school in the prepared binders. Those who helped assemble the notebooks were Mesdames O. Sidney Orth, Adolph Soucek and David L. Williams, Madison, along with Mrs. Thomson and Mrs. Falk.

They then undertook to save vast quantities of postage by distributing the filled binders in person. Distribution began last fall when 100 copies were carried to the Annual Meeting in Milwaukee and given to delegates who took them home for placement in their hometown high schools.

According to Mrs. Falk, physicians' wives throughout Wisconsin have been most cooperative in delivering notebooks. Even the MD's themselves participated! Drs. C. A. Kemper, Chippewa Falls and C. T. Clauson, Bloomer, helped to distribute the books in Chippewa county.

"I should not brag about a few women because so many were essential in making the project a success," said Mrs. Falk, "But I must mention Mrs. Frank Reibold, Superior, who traveled about 225 miles making personal deliveries in Douglas, Burnett and Washburn counties. Mrs. J. S. Huebner, Fond du Lac, and I went northwest as far as St. Croix county distributing brochures in districts where there are no organized auxiliaries."



MRS. VICTOR S. FALK, JR., Edgerton, Nurse Recruitment Chairman of the Woman's Auxiliary to the State Medical Society, meets with two members of her committee. Shown, left to right, Mrs. Albert G. Martin, Milwaukee, Nurse Recruitment Coordinator for the auxiliary; Mrs. Louis E. Fazen, Jr., Racine, who is in charge of Future Nurse Clubs, and Mrs. Falk. Mrs. E. F. Cummings, Oshkosh, Mrs. Herbert Frank, Green Bay and Mrs. George H. Thomson, Beloit are other members of the committee.

Physicians' wives who have delivered the brochures have also accepted the responsibility of servicing them. They check them every so often to be sure none of the bulletins placed in them at the start have been carried off or mislaid. They report on the condition of the book in general.

Letters will go out annually to all nursing schools, asking whether their booklets are still up to date, and when a new brochure is put out by any school, 500 copies of it will be sent to State Nursing headquarters for replacement of the old ones now in the binders.

Work on Speakers Bureau

The recruitment committee is currently working on a new project —that of sponsoring a series of Nurse Recruitment Training Institutes aimed at informing interested persons so that they can sign up for a Nurse Recruitment Speakers' Bureau. Thirteen institutes have now been scheduled, the first having been held in Milwaukee February 24.

Once the speakers' bureau is well established, the committee plans to go all-out for the formation of Future Nurses' Clubs. This is the special project of Mrs. Fazen, and she hopes to begin by starting a few model clubs this spring.

Inquiries regarding the scholarship pages in the note-books indicate that they are being widely read. Mrs. Falk and her committee are encouraged about this and about numerous inquiries they have had from auxiliaries in other states who are anxious to finance similar programs in their own high schools.

Zablocki Would Make Your Wig Deductible

Washington, D. C., Feb. 8.—Representative C. J. Zablocki would amend the medical expense provisions of income tax law to allow deduction for cost of wigs or transformations from taxable income.

The cost would be deductible "only if the individual would, except for the wig, be seriously handicapped by the loss of hair in becoming, or continuing to be, gainfully employed or self-employed in his occupational field."

The bill was referred to the Ways and Means committee.

HIGH SCHOOLS VOLUNTEER COMMENTS ON NURSE RECRUITMENT NOTEBOOKS

"I am sure that this material will prove most helpful in our guidance work, and I want to assure you that extensive use will be made of it."—William Horlick high school, Racine.

"We feel your binder is valuable to us for many of the girls come in seeking just that information."—Saint Catherine's high school, Racine.

"Thanks. It is excellent for our 'Career Corner'."—Wisconsin high school, Madison.

"This is a very useful volume and definitely worth its cost." —Kaukauna high school.

"We appreciate immensely your splendid project and thank you very much."—Marinette high school.

"Thanks for the excellent guidance notebook. It is in the school library for use by the students."—Hartford high school.

"This is greatly appreciated and though expensive, I believe you have something that will pay dividends. It is here! I'd like to suggest the same idea at our state colleges."—Almond high school.

"This is one of the best executed projects I have seen. We greatly appreciate it."—Appleton high school.

"Thank you so much. It is an excellent idea. It has already been used many times."—New Richmond high school.

"Thank you. This brochure should be very helpful for those interested in nursing. I like the way it is organized."—Peshtigo high school.

"It is one of the finest gifts we have ever received."—Madison East high school.

Health Ministry Asks Druggists to Gamble

Chicago, February 11.—Britain's ministry of health has invited druggists to whom it owes money under the state-run national health service to take part in a "lottery" to recover their cash. So says the Insurance Economic Survey, quoting from the Manchester Guardian.

According to the Guardian, the ministry has fallen behind in pricing the millions of prescriptions dispensed by druggists the past year. Under the health service, druggists hand over medicines ordered and then forward the prescriptions to the ministry for payment.

As a result of the delay, the ministry is asking each druggist if he will allow medicines supplied between February and May of the past year to remain unpriced and instead accept a sum calculated on the basis of prescriptions he dispensed in the preceding months.

The average druggist might well either win or lose as much as 50 pounds, or about $140 on this gamble. Druggists who decline to accept must continue waiting for their money.

RESEARCH DRAINS FUNDS FROM MEDICAL EDUCATION, CLAIMS CORNELL DEAN

Chicago, Feb. 9.—Funds for medical education are being drained by government and private sponsors of research, according to Joseph C. Hinsey, Ph.D., dean of the Cornell University Medical College.

Speaking before the 49th annual Congress on Medical Education and Licensure, Dr. Hinsey claimed that the situation is critical enough to "urgently require corrective action."

He pointed out that 65 per cent of the $180,000,000 spent for medical research last year came from government sources, and that many of the grants were not large enough to cover the direct administrative costs of the projects. These costs therefore came out of the limited operating funds of the schools at which the projects were undertaken.

The teaching staffs of medical schools are also being affected by research, Dr. Hinsey continued, saying that the national institutes, backed with the federal tax dollar, have a staff of 750 full-time scientists and are now making attractive offers to some of our most able young teachers.

"With the Armed Forces drafting them on one side and this constant drain to the Public Health Service and industry on the other, it is no wonder that medical school deans are seriously worried," he said.

Many teaching hospitals also have financial difficulties, Dr. Hinsey said. He attributed this, in part, to the hospitals being "inadequately compensated for the services they render, both by welfare and governmental agencies and by voluntary insurance companies."

Urging that more young men be trained as physicians, Dr. Hinsey stressed that the training should be done without lowering the standards of medical education.

He also touched on the problem of the dearth of clinical material in our teaching hospitals as a result of prepayment insurance. Said Dr. Hinsey, "Looking forward to the almost certain development of prepayment insurance for ambulant comprehensive care, as well as for hospital care, we must continue to interest ourselves with the impact of this upon our teaching material, both for our undergraduates and graduates."

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

Hospital Construction Act Would Be Extended To 1960 by Hill, Taft

Washington, D. C., Feb. 20.—Two new bills of interest to the medical profession were introduced in the Senate this past week. One would extend the Hill–Burton hospital construction act from June 30, 1955 to June 30, 1960. The other deals with tax relief for the permanently and totally disabled, allowing a $600 exemption to a disabled taxpayer.

New legislation which appeared in the House included federal aid to education, a federal board of hospitalization, tax relief for the permanently disabled, additional draft credit for doctors, optometrists in VA, increasing presumption of service connection for amyotrophic lateral sclerosis, federal social security for all and investigation of medical and hospital facilities of VA.

A bill was introduced that would create a select committee of 11 members of the House to investigate the selection of physically defective persons by selective service.

Also introduced was H. J. Res. 171 to outlaw treaties and executive agreements which supersede the laws of the United States. This bill is identical with the Bricker resolution which is supported by 64 senators, and favored by AMA.

Gundersen Re-Elected To Education Foundation

Washington, D. C., Feb. 20.—Dr. Gunnar Gundersen, La Crosse, has been re-elected to a third term on the board of directors of the American Medical Education Foundation.

Others re-elected to third terms are Drs. Elmer L. Henderson, Louisville, president; Donald G. Anderson, Chicago, secretary-treasurer and Edwin S. Hamilton, Kankakee, Ill.; Walter B. Martin, Norfolk, Va.; George F. Lull, Chicago; J. J. Moore, Chicago; Herman G. Weiskotten, Skaneateles, N. Y. and Victor Johnson, Rochester, Minn., directors.

AMA president, Dr. Louis H. Bauer, Hempstead, N. Y., was elected vice-president to succeed Dr. Harvey B. Stone, Baltimore, who resigned. Dr. Stone will continue as a director.

Health Council Refuses To Postpone N. Y. Forum

Washington, D. C., Feb. 20.—The National Health Council has turned down a request by the AMA Board of Trustees that it either cancel or postpone the two-day forum on Truman's Commission on the Health Needs of the Nation which is scheduled for the council's annual meeting in New York March 18–20.

The trustees made their request on the basis that only one volume out of five to be produced by the commission has appeared. That one contains only conclusions and recommendations without providing the basis for such decisions. Even if the other four volumes were published immediately, interested parties would not have time to go over them prior to the New York meeting.

In turning down the trustees' request, Dr. Thomas D. Dublin, executive director of the council stated "Insuperable difficulties presented by the schedules of the 27 program participants and by available meeting accommodations make postponement impossible at this time. Furthermore, the executive committee reaffirmed unanimously the earlier decision of the council that the subject "Advancing the Nation's Health" is an entirely appropriate one for consideration at the council's annual meeting."

AMA Contributes $5,000 For Netherlands Relief

Chicago, Feb. 20.—A $5,000 contribution to physicians in The Netherlands to help alleviate the suffering and devastation brought on by recent flood waters was voted by the Board of Trustees of the American Medical Association during a recent meeting here.

Blue Cross, Hospitals Need Closer Tie-Up, Msgr. McGowan Says

Milwaukee, Feb. 19.—Assertions that Blue Cross enrollment has lost ground while commercial insurance "is making great strides" were made by Msgr. Donald A. McGowan, director of the bureau of hospitals and health of the National Catholic Welfare Conference, Washington, speaking before the annual meeting of the Wisconsin Conference of Catholic Hospitals in Milwaukee on February 18.

The Milwaukee Journal quoted Msgr. McGowan as saying "If Blue Cross and the hospitals can come back to their original partnership, it and the hospitals will fare better." He explained that at its start "Blue Cross was wedded to the hospitals in a sociological movement against the threat of government medicine." Blue Cross became less effective and sympathetic when the American Hospital Association and Blue Cross were legally separated, he claimed.

Not True In Wisconsin

Commenting on these statements L. R. Wheeler, executive secretary of Wisconsin Blue Cross said "Nationally the net enrollment of Blue Cross has increased. Growth ratio is tapering off because the time for rapid enrollment has passed since the large industrial centers have been lined up.

"Blue Cross," he went on, "has continued to grow in Wisconsin above the average for the nation and in 1952 had the largest net growth in its six-state district. It is holding its own in the face of competition from private companies."

He explained that Blue Cross is not separated from the hospitals in this state but is controlled by them as their agent.

Streamlining of Federal Health Setups Proposed

Washington, D. C., Feb. 1.—Dr. Alan Gregg, a member of the Health Resources Advisory Committee and vice-president of the Rockefeller Foundation, proposes establishment of a national council to study, coordinate and clarify health issues.

A reactivated Citizens Committee for the Hoover Report announces that it will launch a new drive this year for governmental reorganization, one phase of which is streamlining of Federal hospitalization and medical care systems.

Dr. Gregg's suggestion of a national clearing-house in the field of health is contained in an article appearing in the January issue of the *Journal of Medical Education.* He wants to see represented on this council, medicine, dentistry, nursing and ancillary professions along with government agencies, insurance groups, voluntary associations and the general public.

DOCTOR DRAFT LAW EXTENSION PROPOSALS REVEALED

Washington, Feb. 13—The defense department's proposals for amending and extending the doctor draft law were disclosed yesterday at a Pentagon meeting attended by representatives of the AMA and eight other professional associations. The main provisions are as follows:

1. All registrants except those in the present priorities I and II would be divided into two groups. First to be taken would be those with no military service, who would be inducted by age, with the youngest going first. Next would be those who have had active duty, with those having the least active duty inducted first. All those remaining in the present priorities I and II are to be called immediately upon expiration of deferrals.

2. The maximum age for inductions would be maintained at 51.

More High Commissions

3. Men called to duty as reservists would be commissioned in grades "commensurate with professional education, experience or ability." In other words, current arbitrary limitations on numbers of higher commissions would be waived in the case of medical officers.

4. The law is to expire July 1, 1955.

5. National and State advisory committees are to be continued and strengthened.

6. World War II service with cobelligerents is to be recognized for purposes of doctor draft.

7. Special $100 pay is not to be disturbed.

8. Reserve commissions would terminate upon completion of stipulated active service.

The AMA Council on National Emergency Medical Service has adopted a position on certain aspects of doctor draft extension which is substantially in agreement with the proposals of the defense department.

The council believes, however, that a continuing effort should be made to effect a lowering of the present ratio of 3.7 physicians per 1,000 troops. It also suggests that attention should be called to the inequitable situations being created by recalling physicians with prior service for the same period of time (24 months) as physicians who never have served.

DR. MILDRED E. SCOTT

Dr. Scott New Heart, TB Control Director on Board of Health

Madison, Feb. 1.—Dr. Mildred E. Scott has been appointed director of the State Board of Health's division of tuberculosis and heart disease control. She succeeds Dr. Pierce D. Nelson who resigned last August.

Dr. Scott, a native of Kansas City, Mo., has been with the U. S. Public Health Service on loan to the Florida and Oregon state boards of health since 1949.

She received her medical degree from the University of Kansas in 1930 and a master of public health degree from Johns Hopkins university in 1949.

"Operation A-Bomb" New Civil Defense Film for Public

Madison, Feb. 20.—"Operation A-bomb" is the name of a new, 16-minute Civil Defense film which was released for its first public showing January 16.

This film, which is in color, is part of the official Marine Corps' footage of the A-bomb blast last May at Yucca Flats, Nevada. It is the first color picture of an atomic bomb explosion made available for public exhibition.

Major General Ralph J. Olson, Wisconsin Director of Civil Defense, suggests that representatives of county medical societies contact local theater managers to request showings of this instructive film.

Beloit Administrator President-Elect of Hospital Association

Milwaukee, Feb. 19.—The Wisconsin Hospital Association, meeting in Milwaukee February 19, named Mrs. Mary Evans, administrator of Beloit Municipal hospital, as president-elect for 1954. She will follow the Rev. A. H. Schmeuszer, administrator of Deaconess hospital, Milwaukee, who is now president.

Other officers elected were David Reynolds, Madison General hospital, first vice-president; Riley McDavid, Kenosha hospital, second vice president and Robert Griffith, of Burlington Memorial hospital, treasurer. Msgr. Edmund J. Goebel, director of Catholic hospitals in Milwaukee, was elected to a three-year term on the board of trustees.

Dr. Crosby Speaks

Conference speakers included Dr. Edwin L. Crosby, president of the American Hospital Association; George Bugbee, the association's executive secretary, Gerald Clark of the industrial engineering department, Wayne University, Detroit; Marion Wright, Harper Hospital, Detroit, Everett Jones, vice president of the publication The Modern Hospital and Mr. Reynolds.

Mr. Bugbee discussed cost controls, saying they must be accepted, not only by the administrative staff but by the medical staff. Physicians sometimes display an "astounding lack of knowledge" of the internal operations of a hospital, Mr. Bugbee said. He stated that industrial engineering has something to offer hospitals, but that methods must "get a lot of adaptation first," since hospitals give personal care.

Medical Group Offers Two $100 Essay Awards

Madison, Feb. 26.—The Wisconsin Academy of General Practice is offering two $100 prizes for the two best essays on the general practice of medicine as a career. The contest is open to senior medical students attending the University of Wisconsin or Marquette university.

Hospital Association Award of Merit Goes To Miss Grace Crafts

Milwaukee, Feb. 19.—Miss Grace T. Crafts, recently retired administrator of Madison General Hospital, was given the Wisconsin Hospital Association's annual award of merit at the association's luncheon meeting in Milwaukee. She was not there to receive it in person.

Miss Crafts became the first nurse to receive the award since it was started 12 years ago. During her 25 years administration at Madison General, the hospital grew from 100 to 400 beds, the new student's dormitory was built and an effective auxiliary was formed.

According to the citation, which was read by Dr. H. M. Coon, superintendent of the University Hospitals, Madison, "With Miss Crafts' energies, wholehearted devotion and skills in teaching, in organization and administration, she has built up for the city of Madison and its surrounding area a monumental Madison General Hospital and at the same time enriched the nursing field, her hospital associations and the lives of many fellow workers as well as untold numbers of patients."

ROBERT DUFOUR

Robert Dufour Named Executive Secretary of General Practice

Milwaukee, Jan. 30.—The Wisconsin Academy of General Practice recently named Robert Dufour to serve as executive secretary. Academy offices are in Milwaukee.

Mr. Dufour, a native of New Hampshire, is a veteran of World War II. He received his B. A. from St. Anselm's College in New Hampshire in 1949 and the following fall came to Marquette to teach writing courses in the school of journalism, where he still teaches. He has completed his work for an M. A. in English while at Marquette and is currently working for an M. A. in Journalism.

Red Cross Will Foot Gamma Globulin Bill; ODM Will Distribute

Washington, Feb. 13.—The cost of producing gamma globulin for the nation has been assumed by the Red Cross, according to the AMA Washington letter. Responsibility for its distribution, however, is being assumed by the Office of Defense Mobilization.

Details of distribution are being evolved by a National Research Council committee of physicians. The plan contemplates allocation of the central supply of gamma globulin to State health officers who will be responsible for its final local use.

Another problem is that of matching supply with demand. Because gamma globulin is considered effective in prevention of paralysis due to poliomyelitis, the public demand for it is expected to outreach the supply by summer.

Although increased blood donations are expected as a result of the publicity on the new Red Cross campaign, there is little or no possibility of producing, in the immediate future, all the gamma globulin that will be desired.

DR. STOVALL . . .

(Continued from page 191)

laboratory science, Dr. Stovall indicated, is constant experimentation with chronic diseases with a view to discovering a means of control or a positive cure. "This," said Dr. Stovall, quoting Sir William Ossler, "Is man's salvation of man," and this is what laboratory science has as its goal.

"The battle," he went on "Has only begun against the virus diseases, many chronic diseases and cancer." He said there are still great strides to be made in the field of preventive medicine.

The doctor concerned with laboratory science, Dr. Stovall stated, does not have the direct personal satisfaction that the medical practitioner derives from seeing a seriously ill patient recover his health and happiness under his ministrations. The laboratory man gains his satisfaction from helping the doctor achieve his sometimes dramatic results.

Dr. Stovall disclaimed credit for the establishment of the new laboratory, saying it could not have been accomplished without the support and cooperation of his assistants, the university, the doctors of the state, the State Board of Health and the state government. He said he only hoped that the fine new building would enable him and his staff to do all they should be able to do for the Wisconsin public because "all of our research is just making mud pies if it doesn't lead to the promotion of a healthier and happier civilization. It doesn't take just bricks and mortar and apparatus to make a laboratory. It takes the men and women working in the building toward a common objective."

In conclusion, Dr. Stovall complimented the Wisconsin legislators and others with whom he had worked to make the new State Laboratory a reality, saying that it "has been a privilege to work with a group of forward-looking citizens who had the courage to act upon their convictions."

Reuther for Program of Magnuson Commission

Washington, Feb. 16.—C. I. O. President Walter P. Reuther went all out last week in support of the program offered by the Truman Commission on the Health Needs of the Nation.

Speaking at the Philip Murray Awards dinner in New York, he called upon President Eisenhower's administration to redeem Republican campaign promises through promotion by the federal government of "a comprehensive health program for all the American people."

Mr. Reuther suggested that the federal government enlist the aid of states and private practitioners and institutions to provide comprehensive medical care, remedial and preventive, for those who could not afford it.

He proposed as a basis for such a program the findings of the commission. He also declared that C.I.O. unions would seek improved health and social security provisions in all future contract negotiations.

Homologous Serum Hepatitis

By MAURICE J. ANSFIELD, M. D.*
Milwaukee

Introduction

A NUMBER of instances are recorded in which inoculation of groups of people with human tissue products (plasma, serum, or lymph) resulted in outbreaks of an illness resembling catarrhal jaundice. A characteristic feature of this illness has been a long incubation period varying between one to six months,[1] with the majority of cases occurring 55 to 135 days following inoculation.[2] One of the first large outbreaks was described by Hirsch[3] and occurred in 1883–1884 among workers in a Bremen shipyard. These workers were vaccinated with human lymph derived from cases of vaccinia, and from one to seven months later jaundice appeared in 191 of 1,289 persons. Lürman[4] in 1885 described a similar outbreak.

Sporadic outbreaks appeared subsequently, but it was not until 1937 when the first report of the development of hepatitis following the injection of a preparation containing human blood serum appeared. Findlay and MacCallum[5] in that year reported the occurrence of hepatitis among British troops following yellow fever vaccination. In 1938, MacNalty[6] drew attention to the fact that jaundice developed in 41 of 109 recipients receiving subcutaneous injections of convalescent measles serum. Despite this and similar reports,[7] little interest was aroused until Findlay[8] in England in 1939, Fox[9] in Brazil in 1942, and Sawyer[10] in this country in 1941 reported a high incidence of jaundice among troops inoculated with yellow fever vaccine. Among U. S. personnel who had received yellow fever vaccine, 25,585 cases developed hepatitis with 62 deaths.[11] The extensive investigations of Findlay[8] and Sawyer[10] definitely showed the human serum in the vaccine as the source of the icterogenic agent. After this outbreak, the human serum component of the vaccine was eliminated.

In 1943,[12] a memorandum was published by medical officers of the Ministry of Health in which the term homologous serum jaundice was first used, and in which it was reported that jaundice had developed in recipients of pooled plasma or serum transfusions.

Etiology and Transmission

Homologous serum hepatitis is an hepatitis syndrome caused by the parenteral entry of an hepatotropic virus. Transmission occurs as the result of the parenteral injection of human blood or its products obtained from carriers of the virus. Homologous serum hepatitis may be transmitted by the administration of blood or plasma,[13,18] vaccines containing human serum,[10,19] convalescent human serum,[6,7a,20,21] and by the use of syringes or needles[22,29] contaminated with hepatitis virus.

It is not known what relationship the serum form of the disease has to the naturally occurring infectious hepatitis, and the question has been advanced[30] as to whether homologous serum hepatitis is not merely the result of the artificial transmission of a virus which, under natural conditions, causes epidemic or sporadic infectious hepatitis.

Epidemiology

The evidence available indicates that at least two varieties or strains of virus are responsible for homologous serum hepatitis.[31,32] Neefe[33] has designated these varieties according to epidemiologic origin. Virus IH has been identified with the syndrome of infectious hepatitis or the naturally occurring epidemic hepatitis formerly known as catarrhal jaundice. Virus SH has been identified with the syndrome of homologous serum hepatitis. It must be emphasized that virus IH may also be transmitted as a result of contamination of blood or its products and may produce homologous serum hepatitis after a two to six week interval. This is in contra-distinction to the hepatitis occurring after the long two to five month interval following transmission with virus SH. Thus, one must keep in mind the fact that hepatitis acquired two weeks to six months after exposure may be of viral etiology and represent "homologous serum hepatitis".[33]

The virus or virus-like organism responsible for homologous serum hepatitis, as well as that of infectious hepatitis, is filtrable.[34,35] Attempts to develop serologic or other tests specific for the causative agents have been unsuccessful.[36,38] These observations, combined with the lack of definitely susceptible laboratory animals, have necessitated the use of human volunteers for most of the fundamental studies in this disease. The virus can be stored for months in the dried state, is resistant to heating at 56° C. in the dried state for one-half hour,[26] may remain alive for three and one-half years in the frozen state,[39] and can be exposed for months to 0.5 per cent of an equal mixture of phenol and ether[26] and other bactericidal agents.[12,26] Hepatitis virus may be present in blood before jaundice appears and without associated clinical symptoms or signs,[31,32,40] and apparently disappears from the blood stream eight to ten weeks after jaundice clears.[41] Attempts to demonstrate this virus in the feces of infected persons have been unsuccessful.[42a,b] Data concerning the presence of this virus

*From the Department of Internal Medicine, Mt. Sinai Hospital and Marquette University School of Medicine.

in the nasopharynx have been inconclusive.[39,42a] A prior attack of homologous serum hepatitis does not produce immunity against infectious hepatitis.[39,40] Cross immunity between virus IH hepatitis and virus SH hepatitis has not been demonstrated.[39,43] Hepatitis virus may be present in high concentration in blood owing to the fact that minute quantities of plasma (.01 cc.) have produced the disease in volunteers.[31,32] Active immunization against either virus SH or virus IH has not yet been demonstrated, and human immune serum (gamma globulin) apparently does not provide passive protection against virus SH.[33]

Incidence

The incidence of homologous serum hepatitis is variable. Spurling[44] reported an attack rate of 7.3 per cent in 1,054 patients who were recipients of plasma transfusions. Brightman and Korns[45] reported 29 cases (4.5 per cent) of jaundice in a total of 649 patients who had received dried pooled plasma intravenously, and not one case occurred in the age group from birth to 19 years. Lehane,[46] in a follow-up of 4,430 patients, calculated that 11.9 per cent of recipients of large pool plasma, 1.3 per cent of recipients of small pool plasma, and 0 8 per cent of persons receiving whole blood were affected. It is becoming increasingly apparent that at least some of the cases of sporadic viral hepatitis, present throughout the year on the medical wards of most large hospitals, may be due to virus SH.[33]

Morbidity and Mortality

The morbidity of homologous serum hepatitis is apparently as great as that of infectious hepatitis. The mortality has varied from 0.2 per cent, reported for the 1942 United States Army outbreak following yellow fever vaccination, to 6 to 19 per cent for smaller outbreaks following inoculation with other materials.[16,20,47] Some observers are convinced that the mortality from virus SH hepatitis is greater than from virus IH hepatitis.

Pathology

The pathology of non-fatal cases of acute hepatitis[48] is an hepatic inflammation of varying intensity and distribution. Histologically, virus SH hepatitis is indistinguishable from virus IH hepatitis. The essential changes are hepatic cell necrosis and autolysis and leukocytic and histiocytic infiltration. The centers of the lobules reveal the earliest of these changes, and the periportal spaces show the greatest cellular infiltration. In mild cases or when the lesion retrogresses, the periportal cell accumulations are the predominant feature. Diffuse hepatitis heals completely and rapidly, as a rule. In some, whose courses are prolonged, slight fibrosis may be noted in the portal zones even after apparent clinical recovery.

The pathology of fatal cases of virus hepatitis[49] is not uniform. Complete destruction of the liver parenchyma, leaving only skeletal remnants of the lobule, may be observed in some areas, whereas in others destruction is incomplete. Only the liver cells apparently are destroyed, the framework and sinusoids remaining unaltered. An inflammatory cellular reaction is observed in and about the areas of destruction. Some of the efferent veins are the site of a marked endophlebitis. In some instances new tissue may appear, which grossly appears nodular or tumor-like, and which microscopically presents an abnormal lobular structure, suggesting hyperplasia of surviving cells. This tissue is markedly ischemic and overladen with bile, apparently due to obstruction in the intralobular canaliculi, the extralobular bile ducts appearing normal. Intense inflammatory changes are noted in the gastrointestinal tract, especially in the cecal region and in the brain. The kidney usually shows a choleric nephrosis. Hemorrhagic changes are frequently observed in the lungs, intestines, heart, and kidney.

In a few patients with virus hepatitis a chronic form of the disease develops. The outcome, in terms of pathologic alteration of those cases in which the disease persists in a chronic form for long periods, has not been definitely established. It has been suggested that in some of the cases portal cirrhosis may develop, but this has not been proved. It has also been suggested that some of the cases of hypertrophic biliary cirrhosis may actually be a chronic form of viral hepatitis. Watson and Hoffbauer[50] suggest the term cholangiolitic cirrhosis as a more appropriate and distinctive term, and differentiate it from the hypertrophic fatty liver which represents an intermediate stage between the fatty liver and the atrophic cirrhosis associated with dietary deficiency.

Clinical Aspects

Homologous serum hepatitis is clinically indistinguishable from the naturally occurring infectious hepatitis, although differences in the types of onset which are fairly consistent have been observed. The onset of SH hepatitis is likely to be insidious with a slowly progressive increase in symptoms, and the temperature frequently is normal throughout the course of the disease. The clinical picture frequently has no resemblance to an acute illness. In contrast, the onset of IH hepatitis, irrespective of whether the portal of entry is oral or parenteral, tends to be abrupt, with fever and general symptoms which are common to a variety of acute illnesses.

Laboratory evidence of hepatic injury is frequently present before clinical symptoms in virus SH hepatitis, and may be delayed two to seven days in virus IH hepatitis. These differences are apparent only during the first few days of both forms of hepatitis. Subsequently, the course of infectious hepatitis and serum hepatitis are entirely similar and are characterized more by the signs of liver injury than by those of an infectious process. Unfortunately, these differences are not always sufficiently reliable or consistent to permit their use for clinical differentiation.

For the sake of convenience, the course of acute hepatitis may be divided into three stages,[51] namely, the preicteric or prodromal stage, the acute or icteric stage, and the convalescent stage. In the absence of jaundice the second stage is known as the acute stage.

The prodromal stage may be one to ten days in duration. The insidious and essentially afebrile onset of homologous serum hepatitis has already been mentioned. General malaise, nausea, anorexia, flatulence, loose stools, intestinal cramps, and vague aches in the right hypochondrium are usually present. If the patient remains ambulatory, noticeable right-sided abdominal pain and spasm may develop due to an enlarging liver. Confusion with an acute abdominal condition can occur, but surgery at this time is hazardous and would likely result in liver failure and death. The presence of a large, tender liver in the absence of leukocytosis should be helpful in the differentiation.

The icteric stage follows the prodromal period and is characterized by jaundice as the symptoms grow more severe. Jaundice continues to increase, as a rule, from three to seven days. At this time what may be designated as the "crisis" occurs; the serum bilirubin begins to recede, bile begins to appear in the stool, and the symptoms abate rather abruptly. Following the crisis, jaundice gradually subsides in from one to three weeks or longer. In non-icteric cases, the prodromal period is continuous with the acute stage and without change in the clinical picture. The chief complication during this stage is liver failure and death. Although the mortality rate is usually low, it is variable. Death rarely occurs in the absence of jaundice, unless damage to the liver is so pronounced and overwhelming that the patient dies before there is time for jaundice to develop. Impending liver failure may be suspected when the serum bilirubin continues to rise for more than ten days in association with persistent nausea and vomiting. Somnolence follows, associated with twitching and irritability, and the characteristic "fetor hepaticus" odor appears on the breath. Laboratory findings suggestive of liver failure are a prothrombin time below 50 per cent of normal, despite adequate parenteral doses of vitamin K (10 mg. daily), or a blood urea nitrogen of less than 10 mg. per cent with a normal non-protein nitrogen.

The convalescent stage begins when jaundice has disappeared. It must be emphasized that the disappearance of jaundice does not necessarily indicate recovery. Patients allowed out of bed immediately after the serum bilirubin reaches normal usually relapse. Too early ambulation frequently produces a recurrence of jaundice, and in some cases the relapse may be more severe than the original attack. The convalescent stage may last two to three weeks.

Chronic hepatitis may develop after any of the acute types previously mentioned.[33,51]

Diagnosis

The diagnosis of acute hepatitis is based on symptoms already described in the prodromal stage in association with certain physical signs and laboratory studies. The most important physical finding is an enlarged, tender liver. This is best detected by jarring, fist percussion over the right costal margin. A small, well localized area of tenderness is often present in the right costovertebral area. The most valuable laboratory findings for early use in hepatitis in order of importance and ease of performance are as follows: bilirubinuria, acholic stools, urobilinogenuria, bilirubinemia, strongly positive Hanger and thymol turbidity tests, and a normal or only slightly elevated alkaline phosphatase value. When the diagnosis remains in doubt, and where feasible, a liver biopsy will aid in clinching the diagnosis. The occurrence of hepatitis in any patient who has had some exposure to the "syringe-needle" source of hepatitis virus during the six months period prior to the onset of the disease should cause the physician to suspect homologous serum hepatitis until proved to be otherwise.

Sequelae

Residuals and sequelae are not uncommon and may manifest themselves in several ways. The condition designated as "chronic active hepatitis," which is characterized by intermittent periods of disability for months or years, develops in from 5 to 10 per cent of properly managed acute cases. Under other circumstances, an incidence as high as 28 per cent has occurred. In a small number of cases some type of fibrosis or cirrhosis of the liver develops, but this group is believed to be relatively small. On the other hand, late follow-up studies suggest that a substantial number of such cases suffer a permanent lowering of hepatic reserve.

Treatment

The treatment of acute hepatitis has undergone radical changes during the last decade,[51,65] and at the present time is on a rational basis. Although no specific treatment has been developed, there are three cardinal principles in the general management of viral hepatitis which are of proved value:

1. Bed rest.
2. Diet.
3. Avoidance of additional factors injurious to the liver.

Bed rest is the most important single therapeutic measure in acute hepatitis. Failure to carry out bed rest during the acute or icteric stage has apparently caused cases of only moderate severity to progress to a fatal issue over a period of weeks. In many instances, the severity and duration of the disease have been greatly increased. Rest should be instituted as soon as hepatitis is suspected and should be carried out until the criteria for ambulation are fulfilled. Rest should be complete, without visitors.

The diet should contain approximately 100 Gm. of protein, 250 Gm. of carbohydrate, and 60 to 65 Gm. of fat. An excess of fat other than butter fat in the diet is poorly tolerated and usually induces nausea and anorexia. The protein may be provided in the form of skimmed milk, skimmed milk powder, and cottage cheese. During the preicteric and icteric stages, the diet should be liquid, soft, or solid, whichever is best tolerated. A fluid intake between 4,000 and 4,500 cc. a day during the first two stages is important. If that amount cannot be taken by mouth, it can be supplemented by intravenous infusions. Moderate restriction of salt is advisable. Intravenous saline should not be given unless severe vomiting is present, owing to the increased tendency to retain sodium in the presence of liver damage. Dietary adjuvants, such as methionine, choline, and inositol, are unnecessary unless the patient is poorly nourished at the onset of the illness or he is unable to ingest food for five days or longer. Vitamins have no definite value in acute liver diseases. It has been suggested that if given in excess they probably increase liver damage. One multivitamin capsule daily is adequate. If there is inability to take food by mouth, 200 mg. of nicotinamide should be given because of the large fluid intake. Liver extract is not indicated in acute liver disease. Parenteral vitamin K (10 mg.) should be given each day to patients who have a prolonged prothrombin time. Small whole blood transfusions (100 cc.) should be given every other day or as necessary if the prothrombin time continues markedly prolonged in spite of vitamin K therapy. Recent reports[50] indicate that the use of aureomycin or terramycin may aid in favorably influencing the treatment of viral hepatitis. However, as Capps[51] has pointed out, the danger of inducing diarrhea which is harmful to the liver may outweigh the theoretical advantages of these newer antibiotics. The use of sulfonamides is definitely contraindicated because of their potential toxic effect on the liver.

An already injured liver is readily vulnerable to toxic agents which ordinarily would have little effect. This is applicable particularly to the preicteric and early icteric stages when the greatest amount of acute liver cell damage is present. Additional liver trauma during the early stages of hepatitis may induce acute liver failure and death. Later, in the course of hepatitis, an exacerbation may result. The most common causes of additional trauma are surgical operations, secondary infections, and exposure to various toxic substances, notably alcohol.

Trauma to tissues due to surgery and exposure to anesthetics, such as ether, chloroform, and possibly ethylene, are particularly deleterious. In cases of emergency, it is recommended that local or spinal anesthesia be administered.

Virus pneumonia, diarrhea, and malaria, which by themselves produce marked alterations in liver function even in normal individuals, are serious hazards in acute hepatitis. It is therefore important to prevent these disorders and to promptly control them once they develop.

Alcohol in any form will produce severe exacerbations. Laxatives and purges should not be given. Enemas should be given for constipation. Opiates and short-acting barbiturates are probably detoxified or excreted by the liver and have a prolonged and exaggerated effect in the presence of liver disease and should accordingly not be given.

Oxygen should be administered in the presence of coma in acute hepatitis. Aureomycin or terramycin is also recommended for intravenous use in cases of coma in doses of 1.0 to 2.0 Gm. in 24 hours.

Capps[51] has outlined the following criteria for permitting ambulatory status to patients with acute hepatitis:

1. At least three weeks of bed rest.
2. Disappearance of symptoms such as anorexia, lassitude, diarrhea, cramps, gaseous distention, and headache.
3. Liver not enlarged and not tender. Absence of tenderness in the costovertebral angle.
4. Normal serum bilirubin for one week. If slightly elevated, direct van den Bergh should be negative.
5. Bromsulfalein retention (5 mg./Kg. dose) should be under 7 per cent in 45 minutes. It is desirable to have normal flocculation tests and normal alkaline phosphatase values.

If only one finding is positive, the patient should be kept in bed one extra week, after which ambulatory status may be tried. More conservative management is advocated in chronic or recurrent cases, in severely acute cases, if previous liver injury is suspected, and in patients past 40 years of age.

Purpose of This Study

During the past decade hundreds of thousands of cases of homologous serum hepatitis have occurred among military personnel and civilians in various parts of the world. With the increasing use of plasma, whole blood and blood products, the number of cases of homologous serum hepatitis will proportionately increase. Recent reports have called attention to the occurrence of virus SH hepatitis following transfusions of pooled plasma or whole blood in civilian hospitals.[57, 60]

It is the purpose of this paper to record the experience with this disease at the Mt. Sinai Hospital from January 1943 to January 1951, and to discuss suggested methods of prevention and control of homologous serum hepatitis.

Materials and Methods

During the earlier years of this study, the blood from donors was obtained and kept in the blood bank of the Mt. Sinai Hospital. During the latter part of this study, blood and plasma were obtained from the Junior League Blood Center of Milwau-

kee, Inc. Some of the plasma specimens were obtained from the American Red Cross.

The incidence of homologous serum hepatitis in the Mt. Sinai Hospital was determined by a review of the records during the eight year period with the following diagnoses: (1) infectious hepatitis, (2) acute catarrhal jaundice, (3) homologous serum hepatitis, or (4) jaundice associated with diseases of the liver or biliary tract. Patients were chosen in whom jaundice occurred a few weeks to six months following blood and/or plasma transfusions. A considerable number showing other possible causes of jaundice were excluded. The collection of patients discussed here fulfill the criteria for the diagnosis of homologous serum hepatitis, described earlier in this paper.

Results

During the eight year period from 1943 to 1950 inclusive, 11 cases of homologous serum hepatitis, presumably due to transfusions of plasma and/or blood, occurred. Of these, one received the probable icterogenic material in another hospital; the remaining 10 received plasma and/or blood at the Mt. Sinai Hospital. During this period, there were in the hospital 175 beds exclusive of newborn, with an annual rate of admission exclusive of newborn (1947) of 7,860, and an average daily census of 146, exclusive of newborn. Of the 11 cases presented, none occurred in 1945, and one occurred in each of the other years, with 2 additional cases occurring in both 1944 and 1946.

The 11 patients ranged from 23 to 64 years of age, with an average of 40 years. There were 10 recoveries and 1 death. There were 4 males and 7 females. The majority of patients (8) received blood and/or plasma in relation to surgical procedures. Three medical patients were included in the group. The incubation period for each patient was calculated from the dates of transfusion of plasma and/or blood to the recognition of jaundice. The minimum and maximum possible incubation periods for blood and plasma ranged from 42 to 119 days. For plasma, the minimum and maximum possible incubation periods ranged from 32 to 121 days. During the eight year period, 3,745 plasma transfusions and 8,181 blood transfusions were administered.

Report of Cases

Case 1—E.A., a 30 year old white female, was first admitted to the Mt. Sinai Hospital on Feb. 21, 1943. A supra-vaginal hysterectomy was performed. Postoperatively, a paralytic ileus developed and the patient had a stormy course. Several whole blood and plasma transfusions were administered. She was dismissed as recovered on March 14, 1943. By May 1, 1943, epigastric discomfort, nausea, weakness, and jaundice without fever had developed. Serum bilirubin was 28.7 mg. per cent, there was a four plus Hanger test after 24 and 48 hours, and the urine was positive for bile. Urine urobilinogen was 1.7 mg. excreted in 2 hours. Jaundice and laboratory studies gradually cleared, and the patient was discharged from the hospital after the second admission on May 29, 1943, for complete convalescence at home.

Case 2—H.O., a 38 year old white male, was admitted to Mt. Sinai Hospital on Sept. 9, 1944, with the diagnosis of acute gastroenteritis. The patient received 250 cc. of pooled plasma and intravenous glucose and saline infusions, and was discharged from the hospital after an uneventful recovery. He was readmitted on Oct. 3, 1944, with jaundice and without fever. Laboratory data: Serum bilirubin measured 10.5 mg. per cent, the cephalin cholesterol flocculation test was four plus after 24 and 48 hours, the urine urobilinogen was markedly increased. The urine was strongly positive for bile. The jaundice cleared, and the patient was dismissed on Nov. 19, 1944.

Case 3—A. J. F., a 64 year old white male, was operated for a perforated peptic ulcer at Mt. Sinai Hospital on Nov. 8, 1944. Two plasma and two blood transfusions were administered. He was discharged after an uneventful recovery and was readmitted on Dec. 22, 1944, with jaundice and without fever. Laboratory data: Serum bilirubin measured 7.9 mg. per cent and rose to 19.8 mg. per cent. The urine was strongly positive for bile. The urine urobilinogen excretion measured 2.1 mg. in 2 hours. The Hanger test was three plus after 24 hours and four plus after 48 hours. His jaundice gradually cleared, and he was discharged on Feb. 19, 1945, for convalescence at home.

Case 4—S. G., a 34 year old white female, had suffered an incomplete miscarriage on June 23, 1945. Pooled plasma, 250 cc., and a whole blood transfusion were given. She was dismissed on June 29, 1945, and readmitted on Aug. 8, 1945, with jaundice, dark urine, and no fever. Laboratory data: Serum bilirubin measured 12.9 mg. per cent, the urine urobilinogen excretion was 2.1 mg. in 2 hours, and the urine was strongly positive for bile. She was dismissed on Aug. 24, 1945, when her serum bilirubin measured 1.8 mg. per cent.

Case 5—R. M., a 54 year old white female, was in an automobile accident on Sept. 5, 1946. She was admitted to Mt. Sinai Hospital and given 500 cc. of pooled plasma to combat shock. She made an uneventful recovery and was discharged from the hospital. On Nov. 5, 1946, she was readmitted with jaundice and absence of fever. Laboratory data: Serum bilirubin measured 30.3 mg. per cent. Serum van den Bergh was positive, immediate, direct. Cephalin cholesterol flocculation was four plus after 24 hours and 48 hours. The urine was strongly positive for bile. Jaundice deepened. Somnolence supervened, and the patient expired on Nov. 16, 1946.

Case 6—M. F., a 50 year old white female, was operated at Mt. Sinai Hospital on March 2, 1946, for a perforated appendix. Blood and plasma transfusions were given. Recovery was uneventful, and the patient was dismissed. Readmittance took place July 30, 1946, with afebrile jaundice, light stools,

and highly colored urine. Laboratory data: The icterus index was 46.1, Hanger's test was four plus after 24 and 48 hours, and the urine was strongly positive for bile. Jaundice subsided and the patient was discharged from the hospital on Aug. 10, 1946.

CASE 7—M. W., a 33 year old white female, underwent a dilatation and curettage following a spontaneous incomplete miscarriage on June 6, 1947. Two hundred and fifty cc. of plasma and two whole blood transfusions of 1,000 cc. were administered. She made an uneventful recovery and was dismissed. She re-entered the hospital on Aug. 8, 1947, with jaundice and absence of fever. Laboratory data: Serum bilirubin measured 16.9 mg. per cent; urine urobilinogen excretion was 1.9 mg. in 2 hours; and the urine was strongly positive for bile. The cephalin cholesterol flocculation test was four plus after 24 and 48 hours. The jaundice cleared, and the laboratory procedures reverted towards normal. The patient was dismissed from the hospital on Aug. 29, 1947.

CASE 8—F. R., age 25, a white female, was given one blood transfusion and 250 cc. of pooled blood plasma on April 9, 1948, at the Mt. Sinai Hospital, because of a retained placenta. She was dismissed after an uneventful recovery. She was readmitted to the hospital on July 2, 1948, with jaundice, dark urine, and no fever. Laboratory data: Serum bilirubin measured 14.7 mg. per cent, urine urobilinogen was increased one plus, thymol turbidity was 5 units, and the Hanger test was four plus after 24 and 48 hours. She was dismissed to her home on July 10, 1948, for further convalescence.

CASE 9—M. Z., a 37 year old white female, underwent a hysterectomy because of uterine fibromata on June 1, 1948, at the Mt. Sinai Hospital. Two hundred and fifty cc. of blood plasma and 500 cc. of whole blood were administered by transfusion during the operative procedure. Recovery was uneventful, and the patient was discharged from the hospital. On readmission to the hospital on Sept. 2, 1948, the patient was jaundiced, and complained of pain in the right hypochondrium. The serum bilirubin measured 16.2 mg. per cent, and the cephalin cholesterol flocculation test was three plus after 24 hours and four plus after 48 hours. The thymol turbidity measured 7 units. Bilirubinuria and increasing urobilinogenuria were present. Convalescence was uneventful, and the patient was dismissed to complete her convalescence at home on Sept. 18, 1948.

CASE 10—A. A., a 52 year old white male, had collapsed in the street on March 22, 1949. He was taken by ambulance to the County Emergency Hospital, where he was given 250 cc. of pooled plasma intravenously. He was dismissed after 72 hours with the diagnosis of la grippe. Afebrile jaundice developed 35 days later, and he was admitted to Mt. Sinai Hospital on April 27, 1949. The urine contained bile. Urobilinogenuria was increased. The cephalin cholesterol flocculation test was four plus after 24 and 48 hours. The thymol turbidity measured 9 units. Recovery was gradual, and the patient was discharged from the hospital on June 1, 1949.

CASE 11—H. J. S., a 23 year old white male, sustained extensive second and third degree burns and was given pooled plasma and whole blood transfusions on Jan. 13, 1950, at the Mt. Sinai Hospital. By March 12, 1950, icterus, light stools, and epigastric fullness with flatulence and mild discomfort in the right upper quadrant had developed. Laboratory data: The icterus index was 63 and the zinc turbidity was 19.8 units. The Hanger test was four plus. The symptoms and abnormal laboratory tests gradually reverted to normal. He was dismissed on June 20, 1950, completely recovered.

Discussion

That there is no exact method to distinguish virus IH hepatitis from virus SH hepatitis is well known. However, presumptive evidence may be obtained to aid in making the distinction between them. Thus, the occurrence of hepatitis after an incubation period of a few weeks to six months following plasma or blood transfusion strongly suggests that the hepatitis is of the homologous serum variety.

The data recorded in this study are in general agreement with the results of similar investigations of others on the occurrence of virus SH hepatitis after transfusions of pooled plasma and/or whole blood. The incidence of disease after transfusions of whole blood and/or plasma is lower than reported from other civilian general hospitals in this country.[58,59] The exact explanation of such differences is not known, and it is likely that they result from a combination of factors which include susceptibility of host, virulence of virus strain, dosage of infecting virus, number of donors contributing to pools, and variations in completeness of follow-up of recipients. It is to be realized that records are available only in blood plasma and whole blood recipients who returned to the Mt. Sinai Hospital with jaundice. Doubtless, hepatitis developed in other recipients and was treated elsewhere, although no data is available concerning the latter. The addition of these cases of hepatitis to those treated at the Mt. Sinai Hospital would naturally increase the hospital's incidence of homologous serum hepatitis.

The available information would suggest that the minimal incidence of hepatitis associated with blood and plasma is approximately as follows:[33,44,45]

Material	*Incidence of Hepatitis*
Whole blood	0.6 to 0.8 per cent
Small plasma pools (5 to 10 units)	1.5 per cent
Large plasma pools (1,000 to 5,000 units)	4.5 to 12.0 per cent

These figures do not include the cases of hepatitis without jaundice. It is thus apparent that there is a serious risk in the use of large plasma pools and

a smaller but definite risk in the use of either small plasma or whole blood pools. The risk of the latter is often increased by the frequent need for repeated transfusions by the same patient.

The problems associated with hepatitis viremia unfortunately extend beyond those involved in blood and plasma transfusions. These include the many potential sources of infection from blood through purposeful (transfusions, immunizations, and infusions) or accidental parenteral or oral introduction of blood or its products (syringes, needles, lancets, or contamination of broken skin and mucous membranes).

Prevention and Control

Much has been written on the blood borne virus hepatitis, but little has been discussed concerning measures designed to reduce the incidence of homologous serum hepatitis. It appears that Neefe has perhaps placed sufficient emphasis on prevention and control of this serious and widespread disease, and has suggested several useful measures to reduce the incidence of this disease.[33]

1. *Inactivation of Hepatitis Virus in Blood and Blood Products:* The resistance of hepatitis viruses to methods or conditions which inactivate or eliminate many pathogens makes this a very difficult problem owing to the fact that most procedures capable of inactivating hepatitis virus are also injurious to blood and plasma. Oliphant in 1944, in an effort to find some solution to this problem, first suggested ultraviolet irradiation of plasma for inactivation of hepatitis virus in plasma.[30] Stokes, Blanchard, and Wade, in collaboration with Hampil and Spizizen, have shown that one strain of virus SH in plasma can be inactivated by plasma irradiation.[61] Thus, it appears that carefully controlled ultraviolet irradiation of plasma provides one method of reducing the incidence of this disease. That all strains of hepatitis virus cannot be inactivated in this manner has been demonstrated in recent reports.[62] The technical difficulties involved with ultraviolet irradiation are substantial, and the present technic is not applicable to whole blood. Promising hopes of a generally useful method stem from recent observations which suggest that some viruses may be inactivated by small amounts of specific chemical agents, which when added to blood or plasma produce no serious alterations of these products, and constitute no danger to the person who will subsequently be the recipient of these materials.[63]

2. *Prevention of the Disease in Recipients of Blood and Its Products:* The use of human immune serum (gamma globulin) to prevent virus IH hepatitis when injected during the incubation period of the disease was demonstrated by Stokes and Neefe in 1945.[64] Unfortunately, studies to date reveal that even large and repeated doses of gamma globulin fail to prevent homologous serum hepatitis. However, the fact that some cases of blood transmitted hepatitis are caused by virus IH probably warrants the administration of gamma globulin prophylactically, when multiple transfusions of blood and non-irradiated plasma are contemplated. As a prophylactic measure, this would also be desirable in recognized exposures occurring through the so-called accidental sources.

3. *Selection of Materials as a Method of Reducing Incidence:* Until the present time, gamma globulin and heat treated human serum albumin are apparently the only blood products which can be classed as free from the risk of serum hepatitis.[65] It would thus appear that there is a greater risk with some blood products than with others and it is suggested that reduction in incidence of virus SH hepatitis may be brought about by limiting, when possible, those products identified with greater risk. When a choice is available, heat treated human serum albumin solution and possibly ultraviolet irradiated plasma may be regarded as having a minimal risk, whereas the maximal risk would be undertaken in the use of large plasma pools. Whole blood and single plasma units are attended by a small risk, whereas small plasma pools and multiple transfusions of whole blood or single plasma units are regarded with moderate risk.

4. *Detection of Infected Donors:* This would probably be the ideal measure of prevention. However, a practical, rapid method for demonstrating hepatitis virus in blood has not been developed to date. It appears that some infectious donors could be detected by the routine performance of a small battery of laboratory tests as follows:

A. Physical examination, placing special emphasis on the liver.

B. Exclusion of donors with past history of hepatitis or unexplained recent symptoms or illness.

C. Tests to screen for liver disturbance:

(1) Before donor is bled.
- a. Urine urobilinogen.
- b. Urine bilirubin.
- c. Exclusion of donor if either test is positive.

(2) After blood is drawn, but before releasing blood.
- a. Serum bilirubin—total and prompt direct reacting.
- b. Cephalin cholesterol flocculation test (24 hours).
- c. Thymol turbidity and flocculation tests.
- d. No blood is released if any of these tests is positive.

All professional donors should have a periodic physical examination and a bromsulfalein test in addition to a careful "hepatic" history. Even with such donor selection, carriers without history of apparent infection and without laboratory signs of hepatic disturbance must be presumed to exist and will escape attention.

5. *Prevention of "Accidental Mechanisms" of Transmission:* Evidence of transmission by improperly sterilized syringes and needles and other accidental mechanisms, described previously, exists, and the hazard from these sources must be recognized.[26-29] Until it is proved that the frequency from this source is insignificant, it becomes necessary to use individual properly sterilized syringes, needles, and other devices that penetrate the skin. Proper and thorough cleansing of syringes, needles, and other instruments is of primary importance. If this practice is observed, it is likely that complete immersion in boiling water for 15 minutes would be regarded as adequate sterilization.[33] Moreover, if care is exercised to provide complete contact of all surfaces of properly cleansed needles, syringes, lancets, and other instruments with potent chemical disinfectants for at least one full hour, it is probable that adequate sterilization would be accomplished. Regardless of the method used, heat sterilization is best, and the autoclave is the method of choice.

The greatest precautions must be exercised by those who are in contact with blood or blood contaminated materials or objects during the course of treatment of patients with suspected or recognized hepatitis.

Summary

1. Homologous serum hepatitis is presented as a syndrome caused by the parenteral entry into the body of a filterable hepatotropic virus.

2. The recent advances in knowledge concerning etiology, epidemiology, clinical aspects, and treatment are considered.

3. The experience with homologous serum hepatitis in a civilian general hospital during an eight year period from 1943 to 1951 is presented.

4. The problems associated with the prevention and control of homologous serum hepatitis are reviewed and possible measures of reducing the incidence of this form of hepatitis are discussed.

---

208 East Wisconsin Avenue.

REFERENCES

1. Outbreak of Jaundice in the Army, Circular Letter No. 95, Office of the Surgeon General, J.A.M.A. 120:51–53 (Sept. 5) 1942.
2. Neefe, J. R.: Viral hepatitis; consideration of certain aspects of current importance to the practicing physician, New England J. Med. 240:-445–448 (March 24) 1949.
3. Hirsch, A.: Handbook of Geographical and Historical Pathology, translated from the second German edition by C. Creighton, London, New Sydenham Society, 1936, Vol. 3.
4. Lürman. An Icterus Epidemic, Berliner Klin. Woch. 22:20, 1885.
5. Findlay, G. M., and MacCallum, F. O.: Note on acute hepatitis and yellow fever immunization, Tr. Roy. Soc. Trop. Med. & Hyg. 31:297–308, (Nov.) 1937.
6. McNalty, A. S.: Acute Infectious Jaundice and Administration of Measles Serum, in On the State of the Public Health: Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1937, London, His Majesty's Stationery Office, 1938.
7. a. Propert, S. A.: Hepatitis after prophylactic serum, in Correspondence, Brit. M. J. 2:677–678 (Sept. 24) 1938.
   b. Morgan, H. V., and Williamson, D. A. J.: Jaundice following administration of human blood products, Brit. M. J. 1:750–753 (June 19) 1943.
8. Findlay, G. M., MacCallum, F. O., and Murgatroyd, F.: Observations bearing on etiology of infective hepatitis (so-called epidemic catarrhal jaundice), Tr. Roy. Soc. Trop. Med. & Hyg. 32 575–586 (Feb.) 1939.
9. Fox, J. P., Manso, C., Penna, H. A., and Madureira, Para: Observations on the occurrence of icterus in Brazil following vaccination against yellow fever, Am. J. Hyg. 36:68–116 (July) 1942.
10. Sawyer, W. A., and others: Jaundice in Army personnel in the western region of the United States and its relation to vaccination against yellow fever, Am. J. Hyg. 39:337–430 (May) 1944, ibid. 40:35–107 (July) 1944.
11. Jaundice Following Yellow Fever Vaccination, editorial, J.A.M.A. 119:1110 (Aug. 1) 1942.
12. Homologous Serum Jaundice: Memorandum Prepared by Medical Officers of Ministry of Health, Lancet 1:83–88 (Jan. 16) 1943.
13. Beeson, P. B.: Jaundice occurring 1–4 months after transfusions of blood or plasma; report of 7 cases, J.A.M.A. 121:1332–1334 (Apr. 24) 1943.
14. Steiner, R. E.: Five cases of jaundice following transfusion of whole blood or human plasma, Brit. M. J. 1:110–111 (Jan. 22) 1944.
15. Hepatitis After Transfusion, Editorial, Brit. M. J. 2:279 (Aug. 26) 1944.
16. Rappaport, E. M.: Hepatitis following blood or plasma transfusions; observations in 33 cases, J.A.M.A. 128:932–939 (July 28) 1945.
17. Grossman, C. M., and Saward, E. W: Homologous serum jaundice following administration of commercial pooled plasma, New England J. Med. 234:181–183 (Feb. 7) 1946.
18. Sartwell, P. E.: Infectious hepatitis in relation to blood transfusion, Bull. U. S. Army M. Dept. 7:90–100 (Jan.) 1947.
19. Findlay, G. M., Martin, N. H., and Mitchell, J. B.: Hepatitis after yellow fever inoculation; relation to infective hepatitis, Lancet 2:301 (Sept. 2), 2:340 (Sept. 9) 2:365 (Sept. 16) 1944.
20. Neefe, J. R., Miller, T. G., and Chornock, F. W.: Homologous serum jaundice; review of literature and report of case, Am. J. M. Sc. 207: 626–638 (May) 1944.
21. Beeson, P. B., Chesney, G., and McFarlan, A. M.: Hepatitis following injection of mumps convalescent plasma, Lancet 1:814–815 (June 24) 1944.
22. Bigger, J. W.: Jaundice in syphilitics under treatment, possible transmission of a virus, Lancet 1:457–458 (April 10) 1943.
23. Truelove, S. C., and Hoghen, L. A.: Documentary study of jaundice associated with syphilis treatment and blood transfusion, Brit. J. Social Med. 1:18–32 (Jan.) 1947.
24. Graham, G.: Diabetes mellitus; survey of changes in treatment during last 15 years, Lancet 2:1 (July 2) 1938.
25. Droller, H.: Outbreak of hepatitis in a diabetic clinic, Brit. M. J. 1:623–625 (May 5) 1945.
26. Role of Syringes in Transmission of Jaundice. A Memorandum by Medical Officers of the Ministry of Health, Lancet, 2:116–119 (July 28) 1945.

27. Mendelssohn, K., and Witts, L. J.: Transmission of infection during withdrawal of blood, Brit. M. J. 1:625–626 (May 5) 1945.

28. Capps, R. B., Sborov, V., and Scheifley, C. H.: A syringe-transmitted epidemic of infectious hepatitis, with observations regarding the incidence and nature of infectious donors, J.A.M.A. 136: 819–824 (Mar. 20) 1948; Correction 137:480 (May 29) 1948.

29. Sherwood, P. M.: Outbreak of syringe-transmitted hepatitis with jaundice in hospitalized diabetic patients, Ann. Int. Med. 33:380–396 (Aug.) 1950.

30. Aycock, W. L., and Oren, W. F.: Prolonged incubation period as an epidemiologic principle; infectious hepatitis and homologous serum jaundice, Am. J. M. Sc. 214:483–492 (Nov.) 1947.

31. Havens, W. P., Jr.: Infectious hepatitis, Medicine 27.279–326 (Sept.) 1948.

32. Neefe, J. R.: Recent Advances in the Knowledge of Virus Hepatitis, Med. Clin. N. Am., 1407, 1443 1946, Philadelphia Number.

33. Neefe, J. R.: Viral hepatitis: problems and progress, Ann. Int. Med. 31:857–870 (Nov.) 1949.

34. Neefe, J. R., and Stokes, J. Jr.: Epidemic of infectious hepatitis apparently due to water-borne agent; Epidemiologic observations and transmission experiments in human volunteers, J.A.M.A. 128.1063–1075 (Aug. 11) 1945.

35. Oliphant, J. W., and Hollaender, A.: Homologous serum jaundice; experimental inactivation of etiologic agent in serum by ultraviolet irradiation, Pub. Health Rep. 61:598–602 (April 26) 1946.

36. Oliphant, J. W.: Jaundice following administration of human serum, Harvey Lect. (1943–1944) 39:254–272, 1944.

37. Eaton, M. D., Murphy, W. D., and Hanford, V. L.: Heterogenetic antibodies in acute hepatitis, J. Exper. Med. 79 539–557 (May) 1944.

38. Olitzki, L., and Bernkopf, H.: Precipitation in infective hepatitis, J. Infect. Dis. 77:60–67 (July-Aug.) 1945.

39. Neefe, J. R., Gellis, S. S., and Stokes, J. Jr.: Homologous serum hepatitis and infectious hepatitis, Am. J. Med. 1:3–22 (July) 1946.

40. Paul, J. R., Havens, W. P. Jr., Sabin, A. B., and Philip, C. B.: Transmission experiments in serum jaundice and infectious hepatitis, J.A.M.A. 128: 911–915 (July 28) 1945.

41. MacCallum, F. O., and Bauer, D. J.: Homologous serum jaundice; transmission experiments with human volunteers, Lancet 1:622–627 (May 13) 1944.

42. a. MacCallum, F. O.: Transmission of Arsenotherapy jaundice by blood, Lancet 1:342 (March 17) 1945.
b. Neefe, J. R., Stokes, J. Jr., and Reinhold, J. G.: Oral administration to volunteers of feces from patients with homologous serum hepatitis and infectious (epidemic) hepatitis, Am. J. M. Sc. 210 29–32 (July) 1945.

43. Havens, W. P. Jr.: Experiment in cross immunity between infectious hepatitis and homologous serum jaundice, Proc. Soc. Exper. Biol. & Med. 59:148–150 (June) 1945.

44. Spurling, N., Shone, J., and Vaughan, J.: Incidence, incubation period, and symptomatology of homologous serum jaundice, Brit. M. J. 2:409-412 (Sept. 21) 1946.

45. Brightman, I. J., and Korns, R. F.: Homologous serum jaundice in recipients of pooled plasma, J.A.M.A. 135 268–272 (Oct. 4) 1947.

46. Lehane, D., Kwantes, C. M. S., Upward, M. G., and Thomson, D. R.: Homologous serum jaundice, Brit. M. J. 2:572–574 (Sept. 10) 1949.

47. Grossman, E. B., Stewart, S. G., and Stokes, J. Jr.. Post-transfusion hepatitis in battle casualties and study of its prophylaxis by means of human immune serum globulin, J.A.M.A. 129:991–994 (Dec. 8) 1945.

48. Dible, J. H., McMichael, J., and Sherlock, S. P. V.: Pathology of acute hepatitis: aspiration biopsy studies of epidemic, arsenotherapy and serum jaundice, Lancet 2:402–408 (Oct. 2) 1943.

49. Lucke, B.: Pathology of fatal epidemic hepatitis, Am. J. Path., 20:471–593 (May) 1944.

50. Watson, C. J., and Hoffbauer, F. W.: Problem of prolonged hepatitis with particular reference to cholangiolitic type and to development of cholangiolitic cirrhosis of liver, Ann. Int. Med. 25:-195–227 (Aug.) 1946.

51. Capps, R. B.: Treatment of liver disease, GP 4:69–70 (Nov.) 1951.

52. Barker, M. H., Capps, R. B., and Allen, F. W.: Acute infectious hepatitis in Mediterranean theater, J.A.M.A. 128:997–1003 (Aug. 4) 1945.

53. Barker, M. H., Capps, R. B., and Allen, F. W.: Chronic hepatitis in Mediterranean theater, J.A.M.A. 129:653–659 (Nov. 3) 1945.

54. Hughes, J. D.: Treatment of infectious hepatitis by diet and rest, Bull. U. S. Army M. Dept. 4.662–665 (Dec.) 1945.

55. Hoagland, C. L., and Shank, R. E.: Infectious hepatitis; review of 200 cases, J.A.M.A. 130:-615–621 (Mar. 9) 1946.

56. a. Shaffer, J. M., Farquhar, J. D., Stokes, J. Jr., and Sborov, V. M.: Aureomycin therapy in acute viral hepatitis, Am. J. M. Sc. 220:1–5 (July) 1950.
b. Farquhar, J. D., Stokes, J. Jr., Whitlock, C. M., Bluemle, L. W. Jr., and Gambescia, J. M.: Studies on the use of aureomycin in hepatitic disease, a note on aureomycin therapy in hepatic coma, Am. J. M. Sc. 220:166–172 (Aug.) 1950.

57. Rosenthal, L. T.: Homologous serum hepatitis in a civilian hospital, Gastroenterology 9:28–31 (July 5) 1947.

58. Scheinberg, I. H., Kinney, T. D., and Janeway, C. A.: Homologous serum jaundice, J.A.M.A. 134:841–848 (July 5) 1947.

59. Robinson, J. W., Twaddell, D. N., and Havens, P. W. Jr.: Homologous serum hepatitis, Ann. Int. Med. 32:1019–1027 (June) 1950.

60. Runyan, J., Wright, A. W., and Beebe, R. T.: Homologous serum jaundice, report of 8 fatal cases, J.A.M.A. 144:1065–1068 (Nov. 25) 1950.

61. Blanchard, M. C. and others: Methods of protection against homologous serum hepatitis, the inactivation of hepatitis virus SH with ultraviolet rays, J.A.M.A. 138:341–343 (Oct. 2) 1948.

62. a. Barnett, R. N., Fox, R A., and Snavely, J G.: Hepatitis following use of irradiated human plasma, J.A.M.A. 144:226–228 (Sept. 16) 1950.
b. Rosenthal, N., Bassen, F. A., and Michael, S. R.: Probable transmission of viral hepatitis by ultraviolet irradiated plasma, 3 cases, J.A.M.A. 144:224–226 (Sept. 16) 1950.

63. Hartman, F. W., and others: On the chemical sterilization of blood and blood plasma, Proc. Soc. Exper. Biol. and Med. 70:248–254 (Feb.) 1949.

64. Stokes, J. Jr., and Neefe, J. R.: The prevention and attenuation of infectious hepatitis by gamma globulin, J.A.M.A. 127:144–145 (Jan. 20) 1945.

65. Gellis, S. S., and others: Chemical, clinical and immunological studies on the products of human plasma fractionation; inactivation of the virus of homologous serum hepatitis in solution of normal human serum albumin by means of heat, J. Clin. Investigation 27:239–244 (March) 1948.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Some Other 1952 Developments in Drug Therapy

Last month I confined my review to the infectious diseases; this month I shall range more widely.

In the field of cardiology, we learned that it is advisable to administer Pronestyl intravenously at a slower rate than had heretofore been customary. The controversy regarding the intimate nature of digitalis action in congestive failure continued during the year, and some doubt was cast upon the concept that the diminished minute volume of venous return under the drug is possibly due in part to venous constriction. But the arterial and arteriolar constrictive action of digitalis was confirmed. The DeGraff–Batterman group of investigators in New York City came out during 1952 as champions of gitalin (amorphous) in comparison with Digoxin, their earlier favorite. The clinical status of cation exchange resins in the diuretic therapy of congestive heart failure was somewhat clarified during the year.

Last year there was report that Heparin may be effectively administered sublingually, but this year an independent group of workers deny this. A new tolerance test to guide the clinical use of Heparin, which is based on assessment of patient response to a test dose of the drug, was proposed during the year and may prove to be a valuable aid in practical therapy. The necessity to follow Tromexan-treated cases with prothrombin time studies as fully as Dicumarol-treated cases has been established.

Arterenol was introduced during the year as a promising drug in the treatment of secondary shock, but theoretical considerations and experimental and clinical observations were also produced to favor caution in assuming that this drug is suitable for routine use.

An interesting 1952 observation was that the use of mercurial diuretics and ammonium chloride in individuals with cirrhosis and ascites may provoke hypocalcemia and the sort of symptoms that are attributed to hyponatremia when they occur in connection with similarly induced diuresis in congestive failure.

A disappointment in the dermatologic field was the reported failure of adenosine's alleged ability to relieve pruritus. Evidence also pretty well disposed of the idea that the broad spectrum antibiotics—Aureomycin, Terramycin, Chloromycetin—are effective in herpes zoster.

One of 1952's outstanding developments was the advent of triethylene melamine as a substitute for nitrogen mustard in the lymphomatous diseases. The behavior of this drug raises the hope, at least, of palliative therapy of these maladies without prohibitive toxicity.

An interesting technical development in the field of neuropsychiatry was the combined use of alcohol and Amytal in ambulatory narco-analysis, permitting a considerable reduction in dosage of the barbiturate.

Compound F emerged during the year as probably superior to cortisone in rheumatoid arthritis, but the fact is perhaps not yet fully established. A comparison of the physicochemical properties of salicylate and its isomers has presented the possibility that salicylate action is due to chelate ring formation, a speculation of considerable potential clinical importance since if we can explain salicylate action fully we may advance far toward an understanding of rheumatic fever itself.

An interesting new antithyroid drug, Tapazole, emerged during the year and revealed somewhat greater speed and possibly less total toxicity than propylthiouracil; but unfortunately agranulocytosis has already been reported in association with its use.

There was interesting clinical extension during the year of earlier laboratory observations regarding n-allyl-normorphine's efficacy in treating poisoning with morphine or its congeners.

ACTH and cortisone were used during 1952 with apparent dramatic symptomatic effects in trichinosis, but demonstration of effects upon the larvae in the experimental animal has not been possible. A development of somewhat greater interest in more southerly climes than that of Wisconsin was the threatening by hetrazan of the preferred position of hexylresorcinol in roundworm infestations. This drug is already established as the one of choice in filariasis, loiasis, and onchocerciasis.—HARRY BECKMAN, M. D.

ANNUAL MEETING OF WISCONSIN HEART ASSOCIATION ANNOUNCED

The annual scientific meeting of the Wisconsin Heart Association will be held Saturday, May 23, 1953 in the auditorium of Marquette University School of Medicine.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

REPORT OF A CASE*

HISTORY: This 52 year old white housewife entered the hospital with the complaints of jaundice and generalized pruritus of two and a half years duration. In addition, she had had hemorrhoids, rectal bleeding, and passage of black tarry stools for three months. Three and a half years ago she had had a hysterectomy, apparently for prolapse, and received blood plasma. Ten months later she noticed the onset of a gradually increasing jaundice with clay colored stools and a generalized pruritus and increased frequency of bowel movements to 8 or 9 daily. The jaundice was not unremittingly progressive. She thought that it was less intense at times, and her stools would occasionally be almost normal in color. Occasionally, she had dull cramping pain in the right upper quadrant. Her weight had decreased from 162 pounds to 112. Her local doctor said that enlargement of the liver and spleen had been present almost three years. She had been treated with a low fat diet and choline, and she took Aureomycin frequently for colds. She had received 7 blood transfusions. She had ascites, and this had lessened somewhat after the administration of an intravenous diuretic. Three months ago she began passing black tarry stools as well as bright red blood per rectum. She had hemorrhoids. There were occasional night sweats but no chills or fever. She had a mild exertional dyspnea and ankle edema.

PHYSICAL EXAMINATION: The patient was a deeply jaundiced white female showing evidence of much recent weight loss. The skin was excoriated due to generalized pruritus. She was alert and cooperative. Blood pressure was 120/60. Pulse rate was 92 and respirations 20. There were no spider nevi. The heart was not enlarged. A loud grade III superficial grating systolic murmur was heard over the entire base of the heart but was heard best in the left third interspace. The abdomen was protuberant with a shifting dullness. The liver edge was palpable 11 cm. below the right costal margin and was not obviously nodular. The spleen was palpable 3 fingerbreadths below the left costal margin. Lymph nodes were palpable in the right axilla and both inguinal regions. They were discrete and nontender.

LABORATORY EXAMINATION: Hemoglobin level was 10.2 Gm.; red blood cell count was 4,090,000; and white blood cell count was 6,400 with neutrophils 70; lymphocytes 12; monocytes 8; and eosinophils 2. Slight anisocytosis, macrocytosis, and hypochromia were noted. Total serum protein was 8.4 Gm., with albumin 3.6 and globulin 4.8. Serum bilirubin was 8.4 mg.; direct 7.6. Cholesterol was 4.0, and prothrombin time was 52 per cent. Thymol turbidity was 1.5 units; Hanger's test was negative; and alkaline phosphatase was 62.7. The nonprotein nitrogen level was 36 mg.

X-RAY EXAMINATION: An upper gastrointestinal tract study showed the presence of esophageal varices; otherwise, it was negative. Examination of the chest was essentially negative. Flat plate of the abdomen showed calcification of the gallbladder, with findings suggestive of a stone impacted in the cystic duct. Barium enema demonstrated the presence of a polypoid tumor in the cecum.

COURSE: The patient was prepared for surgery and, at operation, very dense adhesions were found in the vicinity of the gallbladder. Vessels in the region were extremely large. Enlarged lymph nodes were found and removed for study. The common duct was very small. It was isolated and opened with great difficulty and a T-tube finally inserted. The patient received 1,500 cc. of blood during surgery. The cecum was resected. Immediately postoperatively the patient went into shock. Her blood pressure and pulse were unobtainable. Blood was given under pressure and her condition improved. Her urinary output for the first day was 17 cc. Her nonprotein nitrogen rose to 85 mg. and creatinine to 5 in 24 hours. The blood pressure did not rise above 84/44. The pulse rose to 92 once but usually was 40 or 50 per minute. There was no fever. She was irrational, and on the morning of the fourth postoperative day she lapsed into a coma and died.

Clinical Discussion

Dr. J. T. Mendenhall: The protocol today is about a 52 year old woman who was admitted with complaints of jaundice and generalized pruritus of two and a half years duration. She had some other complaints—hemorrhoids, rectal bleeding, and the passage of black tarry stools—but apparently most of those were only of a few months' duration.

On checking through her history, it is of interest that three and a half years before or, in other words, about 10 to 12 months before the onset of the jaundice she had had a hysterectomy and apparently had been given plasma. It does not say whether it was a stock-pool plasma or whether it was a plasma taken off a drawn blood at a small blood bank. However, it does specify that it was 10 months before she noted the onset of jaundice with clay colored stools, generalized pruritus, and increased frequency

* From the University Hospitals and University of Wisconsin Medical School.

of bowel movements. So far, we would like to tie it in with an homologous serum jaundice that has progressed to an actual cirrhosis. With that type of cirrhosis and regeneration of the liver cords, it is not unusual for an intrahepatic obstructive jaundice with clay colored stools to develop. However, the patient also had another symptom; three months ago she began to pass black tarry stools and bright red blood per rectum. She had noticed that she had hemorrhoids, and a little later there was an x-ray diagnosis of a polypoid tumor in the cecum.

I am skipping around in the protocol because the first part of the history would tie in beautifully with one diagnosis if we can assume that she contacted homologous serum jaundice from the plasma, or she might have had infectious jaundice. It also could develop into cirrhosis, to intrahepatic obstruction, and to portal hypertension (she had evidence of that in an enlarged liver and spleen). Her doctor apparently gave her treatment for cirrhosis and portal hypertension with a low fat diet and choline. Why and when she had the 7 blood transfusions is not clear from the protocol. She did have ascites, which would fit in with the diagnosis of portal hypertension and cirrhosis, and she was given the usual treatment of intravenous diuretics.

There is no history of hematemesis. The bright red blood certainly could have resulted from the portal hypertension and the hemorrhoids. The black tarry stools could have resulted from bleeding esophageal varices farther up in the gastrointestinal tract. However, as I mentioned before, we now find another possible cause for the tarry stools—an x-ray diagnosis of a lesion in the cecum.

On physical examination, the patient was deeply jaundiced. There were no spider nevi. I do not think that that rules out cirrhosis. The liver edge was palpable 11 cm. below the costal margin. It was not obviously nodular on physical examination. The spleen was also palpable 3 fingerbreadths below the left costal margin. Whether it is important or not, the lymph nodes in the right axilla and both inguinal regions were palpable. That may be within normal limits.

Laboratory examinations showed an anemia with a hemoglobin of 10.2 Gm. and red blood count of 4,000,000; the red cells were macrocytic hypochromic in type. Serum proteins were totally elevated. I think that the normal for this hospital would be about 6.5 to 6.8. Here there is a relative increase in the globulin which would certainly accompany the cirrhosis. One would expect then that low serum proteins did not have much to do with the ascites. Perhaps it was more on the basis of portal hypertension. Unless she received the 7 blood transfusions fairly recently, I doubt that she had ever had a terribly low serum protein to account for the ascites completely on that basis. Certainly with the cirrhosis she probably had a certain amount of salt retention and electrolyte imbalance, and some of the edema was probably the result of that. She had evidence of increased serum bilirubin, markedly so, and the cholesterol was elevated. This would accompany extrahepatic obstructive jaundice. However, in this case we know that she had been jaundiced off and on for two and a half years. A lot of these liver tests are not necessarily going to add up to any one type of jaundice. Prothrombin time was only 52 per cent, and that would tie in with liver deficiency or obstructive jaundice. Thymol turbidity was within normal limits. Hanger's test was negative. The alkaline phosphatase was markedly elevated. Anything above 15 units, I believe, is more indicative in this kind of picture of actual obstructive jaundice. Here, where it has been of such long duration, it is fairly hard to say.

X-ray examination showed, as we might expect, some esophageal varices. Whether the patient had any bleeding from that we do not know. The flat plate of the abdomen showed calcification of the gallbladder. I assume that they mean the wall of the gallbladder rather than calcification suggestive of stones in the gallbladder or stones impacted in the cystic duct or common duct.

As to the operative notes, in a way it would have been easier for me if they had not said anything because there are a lot of things that I would like to know about the operation that are not mentioned. Very dense adhesions were found in the vicinity of the gallbladder, but no further mention is made as to what the gallbladder was like, whether it had calcification in the wall, or whether it had stones within the gallbladder, or whether a cholecystectomy was done. We have some information here about the region around the gallbladder and the common duct. Vessels in this region were extremely large. I do not know whether that is an indication that she had portal hypertension and that the portal system was extremely large and prominent, or whether these were the vessels that are found with some types of gallbladder disease. Enlarged lymph nodes were found, apparently in the region of the gallbladder or common duct, and were removed for study. They were looking, I suppose, for a carcinoma metastasis. The common duct was very small. It was isolated and opened with a great deal of difficulty and a T-tube was finally inserted. That does not sound as if there was extrahepatic obstruction of the common duct and that the T-tube would actually relieve the jaundice and would short-circuit the bile. However, I am sure that they isolated and opened it with the hope of finding bile in it and of being able to relieve the jaundice. The T-tube was put in for the purpose of helping perhaps and also because once they explored the common duct they felt safer to drain it with a T-tube rather than close it up, even if it was apparently not obstructed.

Evidently, the cecum was resected, and again I do not know whether what I have been told is insufficient or all I should know about it, or whether the patient actually had a right hemicolectomy. If she had a carcinoma of the cecum or of the ascending colon and her condition warranted it, I suspect that a right hemicolectomy was performed for the car-

cinoma there, assuming that the surgeons discovered and confirmed this polypoid tumor. About 25 per cent of tumors of the cecum and ascending colon are polypoid, about 50 per cent of them have penetration of the wall, and about 25 per cent of them have lymph node metastases somewhere in the mesentery. However, I doubt that she would have enough lymph node metastases around the hilum of the liver to actually obstruct the common duct and to offer a reason for extrahepatic obstruction.

Thus far, I would rather tie this case in with the homologous serum, serum jaundice, and cirrhosis and portal hypertension plus the extraneous factor of a coincidental tumor of the right colon. Both of them would lead to anemia. Certainly the cirrhosis would give ascites and could give jaundice. Her terminal event is not hard to see, however. It apparently was a rather difficult operation. Certainly with this portal hypertension she must have bled a lot. She had two procedures done, one on the colon and one in the region of the common duct, and she received 3 transfusions during surgery. However, she had postoperative shock. In a case of cirrhosis, even more so than in any other condition, the hypoxia and the portal hypertension are going to lead to further insufficiency of the liver, liver death or hepatorenal syndrome, whichever you wish to call it. Her nonprotein nitrogen rose, her blood pressure never became satisfactory, and she died on the fourth postoperative day.

My diagnosis is a coincidental tumor in the cecum or ascending colon, homologous serum jaundice, cirrhosis and portal hypertension.

X-Ray Report: **Dr. R. L. Baker:** The films of the lower end of the esophagus showed the esophageal varices. In the flat plate of the abdomen there was a shadow in the region of the gallbladder. Up high was a shadow thought possibly to represent a stone in the cystic duct. The irregular calcified shadow seen on the barium enema film and again calcification up high were present. The barium enema filled well to the cecum, and there was a filling defect characteristic of a polyp. The evacuation film showed it again.

Dr. J. W. Harman: I believe, Doctor Longley, you have the records of the operation performed and the diagnosis reached by the surgical pathologists.

Dr. B. J. Longley: I will read the operative notes first. They tell little more than was in the protocol. "With tremendous difficulty we freed many adhesions which had occurred in the hilum of the liver. The vessels were extremely large and bled readily. Finally, exposure of the liver was obtained, and liver nodes were found in this area which were removed for microscopic study. The common duct was small but was opened and a T-tube inserted. A portion of the liver was taken for biopsy, and the cecum was resected."

Doctor Harman: What about Doctor Jaeschke's report?

Dr. F. P. Nause: As far as the liver is concerned, chronic hepatitis with early cirrhosis and the lymph node, it is difficult to suggest the etiology of this condition; but sarcoid, tuberculosis and brucellosis demand attention. As far as the histopathology is concerned, there was a marked degree of congestion with numerous erythrocytes in the sinusoids. Tubercles were present. They were composed of epithelioid cells and occasional Langhan's giant cells. Incidently, Doctor Jaeschke's diagnosis was "congested node with miliary tubercles," and he had a piece of soft tissue which was diagnosed as connective tissue; also there was a polyp in the cecum which was called malignant.

Doctor Harman: Malignant polyp! It had not invaded the base, though?

Doctor Nause: Doctor Jaeschke's description did not say.

Dr. F. S. Jones: I would like to ask Doctor Mendenhall if he does not think that 10 months is a long time.

Doctor Mendenhall: Well, according to a recent article by Doctor Janeway, five months is the usual maximum incubation period for homologous serum jaundice, and anything over that is suspected of not being due to it, but I made allowances for that in the inaccuracy of the patient and the inaccuracy, perhaps, of the recording here. Also there were 7 transfusions with no mention of when they occurred. The patient could certainly have had an ordinary viral type of hepatitis, and one must consider that fact since the onset was 7 to 10 months after the plasma.

Doctor Harman: I think so. I think that in the observations made by Bradley and his group in England, there were some cases with very long histories.

Necropsy Findings

(W.G.H. 52:203)

Doctor Harman: There was evidence of a recent surgical operation. There was some blood in the abdomen. The bed of the gallbladder was edematous, and the gallbladder was filled with bile and blood. The T-tube was still in place. There were no obstructions to the common duct, as was also observed at surgery, and no extrinsic lesions except for a few large lymph nodes corresponding to those removed by the surgeon. The liver was considerably enlarged, weighed 2,700 Gm., and was a deep green. In it were numerous small areas of recent necrosis up to a centimeter in diameter. Corresponding to the green color of the liver, there was intense jaundice over all the body. The liver was finely nodular but not grossly or massively nodular as is often found in postnecrotic cirrhosis. There were no other significant lesions except that the uterus had been removed, at which time she had received blood originally.

In section through the liver the structure was divided into green patches surrounding lighter yellow zones. At first, we thought grossly that the lighter zones represented areas of regeneration and that in the green areas the bile had accumulated

in the ducts. Another section illustrated the areas of necrosis. At the time of autopsy we believed they were areas of infiltration and, in view of the diagnosis of a granuloma made by the surgical pathologist, favored some kind of superimposed granulomatous infection, possibly Hodgkin's disease, possibly sarcoid. The center was occupied by a yellow necrotic tissue and the periphery by a zone of fibrosis. Another section illustrated the cirrhosis with relatively normal liver adjacent substance, areas of increased proliferation of connective tissue, and small areas of necrosis.

Looking around the head of the pancreas we had noticed grossly some increased edema. I did not consider it very significant at autopsy but took tissue from there to exclude the remote possibility that this might be a carcinoma of the head of the pancreas, and found numerous small areas of focal fat necrosis with a surrounding polymorphonuclear infiltration indicating that it occurred late in the patient's course. However, it was not distributed through the pancreatic tissue itself but in the fat surrounding the organ. We would not define it as acute pancreatic necrosis.

In the kidney most of the glomeruli were normal, but the tubules contained numerous pigmented casts, most of which were biliary pigment but some were hemoglobin. As well as that, there was a minimal vacuolar change occurring in the tubules.

Finally, we found a very interesting change in the skin. There were scattered over the skin numerous small nodules interpreted as lymph nodes by the clinicians. We removed several and when we cut through them found that they were small cystic areas which exuded a bile-stained thin fluid. Microscopically, they were composed of numerous macrophages filled with fat and bile pigment, and some of them were extensively hyalinized.

The decision reached was that the cirrhosis resulted from a progressive chronic hepatitis, ensuing originally, perhaps, from the transfusion which had been given for the hysterectomy, although the period of time between the alleged transfusions and the onset was long. The anatomical evidence of the long-standing jaundice with fibrosis of portal distribution and associated with no conspicuous obstruction of the ducts suggests that the obstruction was in the fine radicals. This case may fit into the cholangiolitic type of cirrhosis. That is what Doctor Jaeschke had in mind, I believe, when he interpreted the biopsy as a chronic hepatitis.

There are a couple of points still hanging. One is the agent responsible for the acute necrosis in the liver. I think that, as Doctor Mendenhall indicated, this was associated with a further derangement of an already compromised hepatic vascular supply. It had already been associated with a portal hypertension, and the surgical manipulation, with the intention of doing the very best for the patient, probably produced a certain degree of incompetency which caused necrosis tantamount to infarct. A similar explanation might be given for the necroses about the head of the pancreas.

The terminal picture is one of hepatorenal syndrome. As the liver failed more severely, it threw an additional burden on the kidney, which was manifested by the rise in nonprotein nitrogen and the creatinine. The polyp was benign, and we had no evidence of any further pathology associated with it because the regional lymph nodes contained no metastases. The lymph nodes resembled the nodules found in the skin and were filled with bile pigment and cholesterol. This probably explains the granulomatous reaction described by Doctor Jaeschke.

Doctor Mendenhall: Perhaps I missed it, but where was the calcification in the wall of the gallbladder, and was there a stone in the cystic duct?

Doctor Harman: There was no stone in the cystic duct. The cystic duct was open, and I did not identify the calcification.

Dr. L. W. Paul: You did not see the varices either?

Doctor Harman: No, we looked for varices particularly but found no varices in the esophagus.

Doctor Paul: It would not be uncommon to fail to find them at autopsy; is that right?

Doctor Harman: I would say it would not be uncommon if you were not looking for them.

Doctor Paul: I was thinking that in the dead individual the veins were collapsed and that they might be difficult to identify.

Doctor Harman: That is true. There might have been dilatation there merely due to congestion, but I would not call that a varix. If there is a varix, it should be a permanent dilatation which even on being emptied gives some indication by the contour of the vessel that there had been a permanent alteration in the vessel size.

Anatomic Diagnosis

Primary: Surgical wound, recent, healing, laparotomy.

- Choledochostomy and cecostomy, recent.
- Ascites (700 cc.).
- Icterus, generalized.
- Cirrhosis, portal (2,700 Gm.), with focal necrosis.
- Splenomegaly (700 Gm.).
- Granuloma, generalized (xanthomata).
- Nephrosis, cholemic and hemoglobinuric.
- Necrosis, focal, pancreas.

Secondary: Scar, surgical, old (hysterectomy).

- Arteriosclerosis, generalized, moderate.
- Adhesions, pleural, bilateral.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 MARCH, 1953 Number 3

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfort—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costella—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Golosinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Govin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

H. K. Tenney—Madison
D. W. Ovitt—Milwaukee
Elwood Mason—Milwaukee
Chalmer Davee—River Falls
G. E. Farkin—Menasha

★

ADVERTISING ADVISORY COMMITTEE

A. L. Tatum—Madison
N. A. Hill—Madison
Harry Beckman—Milwaukee
Mr. Ray T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

The Hernia Problem

"Recurrent Hernias," an article by Ernest A. Ryan, M.D., of Toronto, Canada, in the March issue of *Surgery, Gynecology and Obstetrics*, is refreshing in its approach. In this study of 369 recurrent hernias the author offers no new panaceas, either in operative technic, suture materials, or postoperative care. By checking each one of these cases very closely, he tried to determine just why the hernias recurred. Thirty-six per cent of recurrent hernias occur within the first year, 80 per cent within two years. Practically everyone agrees that these cases are the result of faulty technic or inexpert surgery—such mistakes as failure to ligate the sac properly, failure to strengthen the floor of the canal, and failure to recognize a double hernia.

The recurrence rate reported at the author's hospital—less than 1 per cent in over 5,500 cases repaired initially—is almost phenomenal. Their recurrence rate of 1.3 per cent in their series of recurrent hernias is also unusually low considering the meticulous follow-up.

This article reminds one of the numerous writings of Koch and Allen on the treatment of hand injuries and their constant harping on basic surgical principles. Their results too are in the phenomenal class. Fancy technics, suture materials, or extraordinary methods are no substitute for sound principles of surgery combined with a sound knowledge of the region involved.

Priceless, Yet Free

The American Medical Association's Council Seal of Acceptance offers real protection to the doctor and the public. The importance of this Seal is being dramatized in a series of advertisements currently appearing in the *Wisconsin Medical Journal.*

Manufacturers of drugs, food products, therapeutic and diagnostic devices, and sponsors of voluntary prepaid medical care plans may obtain American Medical Association evaluation of their products without payment of any fee and without obligation to advertise in U. S. medical journals. If these products meet with basic standards, they are awarded the Seal of Acceptance of the American Medical Association Council.

The Seal wields a powerful voluntary influence on the ethical promotion of drugs, foods, and medical equipment. The Council Seal is the doctor's guide to clinically tested products.

Comments from the Wisconsin Press

Toward Better Medical Care

"Dr. Louis H. Bauer, president of the American Medical Association, has outlined a thorough-going program for what he terms "the preservation of our American system of medicine." His constructive points, which are directed to all physicians and to all component societies of the AMA, include:

"Work with rural communities to establish facilities for physicians, so that we shall have a better distribution of physicians.

"See that good medical care for the indigent is available everywhere.

"Extend public health coverage to areas lacking it, and develop plans for the care of the chronic invalid.

"Expand our voluntary health insurance program, not only to cover more persons, but to cover those over age 65 and those suffering from illnesses of long duration.

"See that the public is protected so that it can always obtain the services of physicians.

"Revitalize our county health societies and make them leaders in their communities in all health matters."—Shawano Evening Leader, February 5, 1953.

"Here is the positive answer to those who have attempted to delude the lay public into believing that the only solution to expanding and improved medical service is socialized medicine. The fact is that this country has seen greater progress in medical care under private medical initiative than any other major nation—and the medical fraternity is giving endless thought and concrete effort to making it still better."—Westby Times, February 4, 1953.

The Acid Test

"The principal argument used in advocating socialized medicine is that the cost of adequate medical care is beyond the means of most people.

"That argument, when assayed in the light of certain facts, won't stand the acid test.

"In 1951, for example, we spent about $13,600,000,000 for medical services. In the same year we spent $13,200,000,000 for alcoholic beverages, tobacco and smoking supplies. In other words, the medical care bill was practically the same as the bill for commodities which can't be described as necessities by any stretch of the imagination. . .

"In no other major nation has there been greater medical progress than in the United States—and in none do the masses of the people get such excellent care."—Burlington Free Press, February 17, 1953.

Re the Ex-President's Commission

"The commission . . . seems to feel that the dominant role (in health matters) has to be played by the federal government at an added annual cost to the taxpayer of about 2 billion dollars a year.

"If the taxpayer could ever pay $1 into the federal government for anything and get $1 worth of value, all would be wonderful. But it is true . . . that the taxpayer kicks in a whopping "handling charge" for any service he gets. . .

"We'd like to see the new administration and the new Congress approach the question of the nation's health, not with the idea of increasing federal control over our medical services, but with the determination to aid and further the private efforts of the people, and of their local governments, in seeking their own salvation."—Milwaukee Sentinel, Dec. 26, 1952.

Old Useless Law

"Repealing old, useless laws as well as enacting new measures is a service of the state legislature.

"The State Medical Society has made a nomination in that respect that makes sense. The law that requires the licensing of professional midwives, it suggests, ought to be repealed. It is quite useless today as is shown by the fact that for several years the state board of medical examiners had received not a solitary application for license to practice midwifery.

"Today's babies, it seems, are born under the direction of doctors of medicine, unlike the times in which the midwife regulation statute was produced."—New Glarus Post, February 4, 1953.

Will Doctors Clean House?

"Dr. Louis H. Bauer, president of the American Medical Association, has called upon the nation's physicians and component societies of the association to "clean our own house." This, he said, calls for disciplining "those physicians who are tarnishing the reputation of the whole profession by their unethical acts of overcharging, accepting kickbacks and making commercial arrangements with pharmacists." It is a high sounding statement, doubtless made in all sincerity. Yet, will it be heeded by those members of the profession who feel as strongly about it as Dr. Bauer? It is one thing to remind colleagues of the Oath of Hippocrates and the pledge to "abstain from whatever is deleterious and mischievous," and quite another to crack down on the offenders."—Marinette Eagle-Star, January 7, 1953.

. . . . THE PRESIDENT'S PAGE . . . .

A MUCH discussed question, relative to health, on the national scene today is the status of the Federal Security Agency.

For over half a century, organized medicine has worked for a department of health in the federal government with a secretary of Cabinet rank, preferably a physician. During the past two decades, with the passage of Social Security legislation and later with the formation and growth of the Federal Security Agency, they found health, originally only a question of public health, now threatening to embody medical care for the entire country and entangled with Social Security and education in a rapidly growing empire. The medical profession realized that the proposition that a nation's health is dependent on housing, food, education, and security is true in part but not altogether so, as proponents of the welfare state would have us believe. They recognized that under the last Administration the costs mushroomed for programs of social welfare at home and what appeared to be propaganda abroad. Physicians fought vigorously against Oscar Ewing's campaign to have his agency elevated to a federal department with almost dictatorial powers for himself as head, and against his demands for compulsory government health insurance. Ewing's plan did not represent the kind of medicine they believed was best for the people and the kind they had dedicated their lives to supply. The position of medicine on this matter in the immediate past has been one of definite obstructive influence, and it would seem rightly so.

Now there is a new administrator of this Federal Security Agency and a new plan to establish a department of health, education, and welfare.

Many believe that before such a department is created there should be a thorough investigation of the entire problem by certain committees of Congress, with study of the character and necessity of the programs, the people who have been and are administering them, the huge and increasing expenditures, and the waste and inefficiency that have been apparent.

President Eisenhower has reiterated his dislike of the words "compulsory" and "socialized" and has promised that the Administration will not attempt to be the big 'poobah' in the health field. Senator Taft has explained that investigations will be started soon, not only of the Federal Security Agency but of the basic philosophy of state and federal relations to determine the justification for aid in various fields of health and welfare.

Mrs. Oveta Culp Hobby is the new administrator. She is certain to become the secretary of the department of health, education, and welfare. She is to have a special assistant, a physician with wide non-governmental experience, as her top staff policy advisor with respect to all medical matters within any agency of the department. There has not been time to know fully Mrs. Hobby's social viewpoint, but she has proved herself to be a capable woman in the past. Her successful organization of the WAC during World War II commanded great respect. It would seem that with an individual of this character and with the cooperation of an Administration determined to find the right philosophy in the relation between government and private initiative, organized medicine could well afford to pursue a constructive and cooperative policy toward this new department. Separate agencies have a way of becoming thoroughly independent. In the new plan, the secretary will be subject to the philosophy of the President, the Administration and the Cabinet members, all of whom are normally responsive to public demands. With a secretary of Cabinet rank advised by a recognized medical leader, it would seem that a program can be organized which will be efficient and best for the welfare of the American people.

J. C. Griffith M.D.

OFFICIAL CALL FOR

Scientific Exhibits

★

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6–7–8

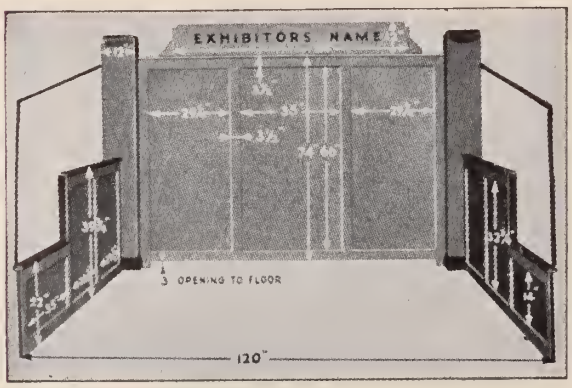
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1953 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1953 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of gray wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to S. A. Morton, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6-7-8

Fill Out and Mail to:

S. A. MORTON, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (attach 200 word description to this blank): _____

3. The standard booth is 10′ wide and 9′ deep. _____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be used? If so will you furnish them? _____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

EXAMINATION DATES SET BY INTERNATIONAL COLLEGE OF SURGEONS

Qualifying examinations for Fellowship in the U. S. Section of the International College of Surgeons will be held on the following dates in 1953: Feb. 2 and 3, May 4 and 5, Aug. 10 and 11, and Nov. 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine and the Cook County Hospital. Applicants are requested to address communications as follows: Harry A. Oberhelman, M. D., Secy., Qualification and Examination Council, 1516 Lake Shore Dr., Chicago 10, Ill.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

WPS Checks

Wisconsin Physicians Service is taking steps to alleviate a problem caused by insufficient space on the WPS check voucher. The check voucher has only 14 horizontal spaces in which to write the names of persons for whom services were rendered by the physician. In some instances, the person's name is so long that it is impossible to print the full last name and a satisfactory abbreviation of the first name in the limited space. When this occurs, some physicians have reported mix-ups when more than one patient has the same last name and first initials.

The WPS office makes every effort to print the person's full first and last name. When space prohibits, attempts will be made at satisfactory abbreviations wherever possible. In the event the confusion still causes difficulty, it is suggested that the physician's office contact WPS for complete details.

It is further suggested that confusion can be prevented by comparing the date of service shown on the check voucher with the date of service shown on the records of patients with the same name.

New check forms with more adequate space are being developed by WPS and will be put into use when the present supply is exhausted.

Ethmoidectomy

When a physician performs an exenteration of ethmoid air cells as a means of enlarging the opening in the frontal sinus for the purpose of repeated irrigations, WPS provides a benefit on the basis that an intra-nasal ethmoidectomy has been performed. In other words, the procedures are considered to be one and the same and the physician should report his services as an "intra-nasal ethmoidectomy" for the purposes of benefit payment.

T & A Benefits

Wisconsin Physicians Service contracts do not provide benefits for tonsillectomies and adenoidectomies performed by deep x-ray therapy. However, payment is provided for T & A as performed by electro-desiccation.

Arthroplasty

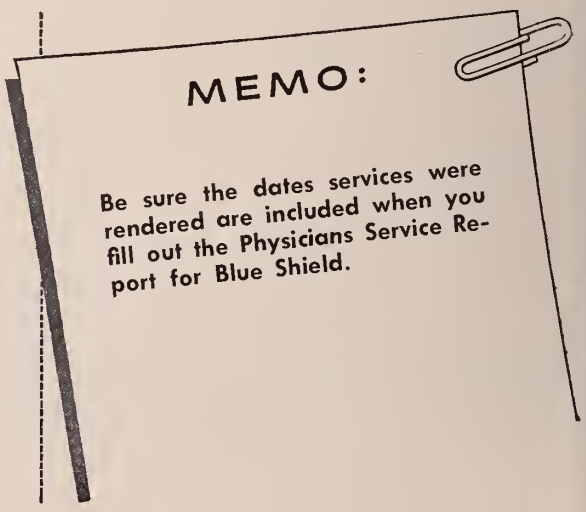
The WPS fee schedule has well established benefit payments for arthroplasty of the elbow, shoulder, wrist, hip, knee, and ankle. Recently, the WPS claims committee authorized payment of arthroplasty of the finger on the same basis, providing a prosthesis is used.

Amputation of Great Toe

The importance of concise reporting of procedures performed by the physician is well illustrated by the benefits available for the amputation of toes. According to the fee schedule, a benefit is provided for the amputation of the first toe with lesser benefits for each additional toe amputated. However, a separate and higher benefit is provided for amputation of the great toe. Description of the specific procedure performed will, in this instance, provide a more adequate benefit.

Bone Graft

Benefits for an ostectomy are provided by WPS in connection with a bone grafting procedure. However, the benefit is computed according to the fee schedule and the multiple procedure formulas applicable to these situations.



Use of Alidase® Permits Subcutaneous Administration of Fluids at Usual Intravenous Rates

In operative states—Alidase circumvents the complicating factors of venous thrombosis and "wornout" veins which frequently make fluid administration by vein difficult and dangerous. Simplicity and safety of Alidase make hypodermoclysis a method of choice for preoperative preparation and postoperative maintenance.

In burns—Plasma and electrolyte solutions can be given subcutaneously at effective rates when Alidase is employed; collapsed veins or risks of thrombosis are not a problem with this method.

Addition of Alidase to the first few cubic centimeters of fluid during hypodermoclysis speeds absorption to a degree approximating that of the intravenous route. Use of highly purified hyaluronidase in this manner avoids the well-known difficulties encountered with venoclysis, saves valuable nursing time and is more comfortable to the patient.

Hechter, Dopkeen and Yudell[1] have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.[2] They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."

In toxemias of pregnancy—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. Searle & Co. *Research in the Service of Medicine*

1. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, J. Pediat. 30:645 (June) 1947.
2. Schwartzman, J.; Henderson, A. T., and King, W. E.: Hyaluronidase in Fluid Administration: A Preliminary Report, J. Pediat. 33:267 (Sept.) 1948.

COMMITTEE *Concentrates*

CLAIMS COMMITTEE
FEBRUARY 4

MDs present: C. G. Reznichek, J. T. Sprague, N. A. Hill, R. C. Parkin.

As usual the meeting was held to settle problem cases brought to the committee by the staff of Blue Shield.

COMMITTEE ON MILITARY MEDICAL SERVICE
FEBRUARY 5

MDs present: F. L. Weston, chairman, M. H. Steen, O. G. Moland, J. M. Sullivan.

Reviewed large number of cases involving essentiality of physicians... Wisconsin reported to have slightly higher percentage of deferred physicians than national average, but this is expected to even out by July 1 when interns and residents complete their service . . . . concurred in AMA's proposals for review of "doctor-draft" law . . . . stressed need for improved utilization of physicians by the Armed Forces.

AUDIT AND BUDGET COMMITTEE
FEBRUARY 7

MDs present: E. M. Dessloch, chairman, J. M. Bell, A. J. McCarey, J. C. Fox, N. J. Wegmann, J. C. Griffith, F. L. Weston.

Detailed report submitted to the Council will appear in Council minutes of its annual meeting.

DIVISION ON HEARING AND VISUAL DEFECTS
FEBRUARY 14

MDs present: T. L. Tolan, chairman, E. J. Zeiss, J. W. Doolittle, Maxine Bennett, H. A. Sincock, Kate P. Newcomb.

As first meeting of the newly formed Division, the major portion of the meeting devoted to a review of the hearing program of the Bureau of Handicapped Children and certain research developments at the University of Wisconsin relative to psychogalvanic skin testing of children whose handicaps are so marked that customary tests cannot be employed . . . . special attention directed to the growing problem of noise in industry and medical problems resulting from compensation claims being based on hearing loss. In early April a meeting is scheduled to work with the Wisconsin Council on Safety and the Wisconsin Manufacturers Association on the development of special conferences next fall, which it is hoped will attract doctors as well as plant management. . . . . Discussion on vision program showed need for more emphasis on this subject, directed to county medical societies and school administrators. A basic guide is being developed which will be submitted to the Council for approval, and it is hoped will direct school visual programs along sound lines, which physicians will approve and supply the needed cooperation. . . . . Need for more information on services of state agencies suggests desirability of reminding all EENT physicians of material carried in July 1952 issue of *Journal*. A special mailing on this is contemplated within the next month.

DIVISION ON HANDICAPPED CHILDREN
FEBRUARY 14

MDs present: H. A. Sincock, chairman, R. C. Waisman, A. B. Weinstein, M. G. Peterman, J. W. Nellen, Kate P. Newcomb, Maxine Bennett, J. W. Doolittle, and T. L. Tolan.

Review of program of Bureau of Handicapped Children laid special stress on need for more realistic program for epileptic children, a shift in emphasis of the orthopedic clinic program, need for more direction on local development of facilities for the rheumatic child, and better coordination between local facilities in care of the cerebral palsied child and state department services. Doctor Weinstein was asked to develop a guide on development of local facilities for the rheumatic fever patient, both as to convalescent care and out-patient service which might be developed through an adequately staffed general hospital.

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY-MANSFIELD DIVISION

GRIEVANCE COMMITTEE
FEBRUARY 14

MDs present: R. E. Fitzgerald, chairman, C. E. Zellmer, E. W. Mason, E. D. Sorenson, H. W. Wirka, H. Kent Tenney.

DIVISION ON MENTAL AND NERVOUS DISEASES
FEBRUARY 15

MDs present: E. D. Schwade, chairman, M. G. Peterman, Sara Geiger, J. E. Gonce, Eugenia Cameron, Owen Otto, Chester Wade, Leslie Osborn, T. W. Tormey, Keith Keane, H. H. Reese, H. K. Tenney, W. J. Urben, and J. T. Petersik.

Morning meeting especially devoted to problems of the psychotic child. Special sub committee serving to cover this subject. As first meeting, mostly devoted to a review of current needs, to what extent study should cover all problems, and procedures to follow. Doctor Peterman will serve as chairman, and Doctors Robert O'Connor and A. A. Lorenz recommended to serve as committee members. Decision to take in all problems of the emotionally disturbed child and not limit to institutional facilities. First project to review and evaluate existing facilities, both public and private, with consultation with key personnel of Division on Children and Youth of Department of Public Welfare. Also agreed to suggest reactivation of project in Milwaukee County which had been proposed and failed to secure financial backing of Board of Supervisors, to set up as pilot study. . . . . Afternoon meeting of Division on Mental and Nervous Diseases stressed need for retaining key personnel and desirability of helping Committee on Military Affairs and Selective Service to establish criteria for essentiality. . . . . Special problem of TB patient in county institutions discussed, and sub committee appointed to consult with State Board of Health and representatives of Division on TB and Chest Diseases to probe matter further and come up with some recommendations. . . . . Problems of trained personnel in two state hospitals discussed, and recommendation made to have meeting with U. of W. Medical School personnel to see what might be done to have hospitals recognized for resident training programs. . . . . Special committee appointed to study state commitment laws and needed revisions, which might be suggested to the legislature in 1955.

COMMITTEE ON BLOOD BANKS
FEBRUARY 19

MDs present: W. D. Stovall, chairman, C. N. Neupert, Tibor Greenwalt, Merle Hamel, Etheldred L. Schafer, and Jack Kamholz.

Major purpose of meeting to review blood procurement programs through Badger Regional Blood Center, Madison, and Milwaukee Junior League Blood Center, Milwaukee, and to review the current status of the programs in relation to stockpiling of gamma globulin for next summer's use in connection with polio. . . . . Review of blood program revealed growing cooperation of local physicians to supervise visits of bloodmobile in their areas, and special problem which exists in Dane County. . . . . Major attention devoted to gamma globulin matter, and preparation of report to Council which suggests need for active participation of the State Medical Society in determination of policies in distribution of gamma globulin as needs arise and requests for allotments are made. An official statement on this subject will be directed to members and to hospitals prior to May 1.

RELATED ACTIVITIES

SMS staff is working with many groups in promotion of Third Governors Conference on Children and Youth, which will be held in Madison on April 24-25. H. Kent Tenney, M.D., president-elect of SMS is general program chairman. . . . . Annual Meeting plans beginning to jell. Scientific programs to be on Tuesday, Oct. 6 through Thursday, Oct. 8. Golf tournament scheduled for Monday afternoon and evening, Oct. 5 so as to avoid conflicts with other features of program. Tentative plans call for first meeting of House of Delegates on Monday a.m. Special program being planned first evening (Tuesday, Oct. 6) in place of "Smoker" which will be combined with Auxiliary, and the Milwaukee Art Institute on interesting art display on "The Story of Medicine in Art". . . . . Big news: Annual Dinner will be a "no dry speech" affair, with music, novelty acts, and fun in character of "Smoker" as featured entertainment. Will meet increasing objection of wives that they are not able to attend fine "Smoker" programs held heretofore. . . . . February post grad clinics well received by physicians in and around Lancaster, Janesville, and Fond du Lac. Programs attracted more than 150 MDs, and many fine comments on practical nature of program offered. . . . . March meetings in Beaver Dam, Marshfield and Neenah are shaping up with good advance registration. Special features: "wet clinic" at Marshfield at 11:00 a.m., to review rheumatic fever cases; Neenah meeting will feature non-scientific evening program with H. Kent Tenney as speaker. Wives to attend, so good attendance assured!

REMINDER: *On Regional Teaching Programs*

If you have not already done so, sign up for the regional meetings listed below which are nearest your home. Registration $6.00, including dinner. (For the June clinics in northern Wisconsin, where wives will attend, joint dinner reservations are $9.00.)

APRIL

TUESDAY, APRIL 14: West Bend (Thoma's Resort, Little Cedar Lake)

WEDNESDAY, APRIL 15: Shawano (Bilmay Hotel)

THURSDAY, APRIL 16: Stevens Point (Whiting Hotel) COUNCILOR DISTRICT MEETING

George E. Collentine, Jr., M.D., Milwaukee, Moderator

(Program from 2:00–5:00 p.m.)

A Clinical Approach to Common Infections: Burton A. Waisbren, M.D., Clinical Instructor of Medicine, Marquette University School of Medicine, Milwaukee

Office Gynecology: Herbert E. Schmitz, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago

Traumatic Surgery as It Concerns the General Practitioner: John T. Reynolds, M.D., Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago

Treatment of Arrhythmias: Richard Langendorf, M.D., Associate Attending Physician and Research Associate, Cardiovascular Department, Michael Reese Hospital, Chicago

MAY

WEDNESDAY, MAY 13: Delavan (Lake Lawn Resort)

THURSDAY, MAY 14: Sheboygan (Pine Hills Country Club)

FRIDAY, MAY 15: Green Bay (Elks Club)

Joseph W. Gale, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Metabolic Problems in General Practice: E. S. Gordon, M.D., Associate Professor of Medicine, University of Wisconsin Medical School, Madison

Recent Advances in Obstetric Practice: John Parks, M.D., Professor and Head of Department of Obstetrics and Gynecology, George Washington University, Washington, D. C.

The Problem of Chronic Cystic Mastitis with Special Reference to Its Relation to Carcinoma: Robert Elman, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis

The Convulsive Disorders in Childhood: M. G. Peterman, M.D., Head of Department of Pediatrics, Milwaukee County Hospital, Milwaukee

JUNE

WEDNESDAY, JUNE 24: Hayward (Radio Joe's Inn)
THURSDAY, JUNE 25: Minocqua (Minocqua Country Club)

PHYSICIANS' WIVES ARE INVITED TO ATTEND THESE CLINICS. SPECIAL ENTERTAINMENT WILL BE PROVIDED.

E. H. Jorris, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Some Newer Concepts Concerning the Prevention and Treatment of the Late Toxemias in Pregnancy: John W. Harris, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison

Recent Advances in Pediatrics of Importance in General Practice: Charles May, M.D., Professor and Head of the Department of Pediatrics, State University of Iowa College of Medicine, Iowa City

The Clinical Significance of Vascular Changes in the Skin: William Bean, M.D., Professor and Chairman of the Department of Internal Medicine, State University of Iowa College of Medicine, Iowa City

Reservation

Fee: $6 each clinic—including dinner

[CHECK CLINICS YOU WILL ATTEND]

APR. 14 (Tues.): West Bend ☐
APR. 15 (Wed.): Shawano ☐
APR. 16 (Thurs.): Stevens Point ☐

MAY 13 (Wed.): Delavan ☐
MAY 14 (Thurs.): Sheboygan ☐
MAY 15 (Fri.): Green Bay ☐

June Clinics:

Wives Invited!
Special Joint Program

JUNE 24 (Wed.): Resort: Hayward ☐
JUNE 25 (Thurs.): Resort: Minocqua ☐

NAME _____

STREET _____

CITY _____

Make check payable to:

STATE MEDICAL SOCIETY OF WISCONSIN

Mail to: Box 1109, Madison, Wis.

Society Proceedings

Barron–Washburn–Sawyer–Burnett

Dr. A. N. Richards of the department of medicine of the University of Minnesota Medical School was the guest speaker at the January 13 meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society, when it met at the Elks Club in Rice Lake. He chose "Surgery in Mitral Stenosis" as the title of his presentation.

The uniform type of insurance surgeon's report for non-compensatory cases, as adopted by the St. Louis County (Minn.) Medical Society, was presented and discussed. *Dr. J. F. Maser* of Rice Lake was appointed by the president of the society to bring up this matter at the Tenth Councilor District meeting.

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society held its monthly meeting on Thursday evening, February 12, at the Elks Club in Green Bay. "Lesions of the Esophagus and Lung" and "Surgical Treatment of Mitral Stenosis" were the titles of two papers presented by *Dr. Forrester Raine*, Milwaukee thoracic surgeon. The March meeting of the society will be held in conjunction with the postgraduate clinic and Councilor District meeting which is to be held on March 26 in Neenah.

Douglas

During Diabetes Week, November 16–22, the Douglas County Medical Society cooperated in a nationwide search, under the auspices of the American Diabetes Association, to find the estimated 1,000,000 persons who have diabetes without knowing it. *Dr. H. B. Christianson*, Superior, was appointed chairman for the detection drive.

When the society met at the Hotel Superior on February 4, Miss Adele Stahl, Madison, director of nursing education of the State Department of Nurses, was the guest speaker. She spoke on the new training school for practical nurses, giving a very informative talk on the value of the school, its capabilities and limitations.

Fond du Lac

Meeting at the Elks Club in Fond du Lac on January 22, members of the Fond du Lac County Medical Society heard a talk by Mr. C. H. Crownhart, secretary of the State Society. Mr. Crownhart spoke on current problems in the State Society with specific reference to the proposed Medical Practice Act. The formal discussants were *Drs. J. M. Sullivan*, Milwaukee; *A. H. Heidner*, West Bend; *A. J. McCarey*, Green Bay; and *A. G. Koehler*, *Oshkosh*. Following an open discussion by members of the society, a motion for approval of the proposed Medical Practice Act was unanimously passed.

Other special guests at the meeting were *Drs. J. R. Nebel* and *G. E. Forkin*, Menasha; *Dr. R. H. Bitter*, Oshkosh; and Mr. S. E. Gavin, Jr., Madison, legislative counsel for the State Society.

Kenosha

The most recent meeting of the Kenosha County Medical Society was held at the Elks Club in Kenosha on February 5. Dr. Harry A. Oberhelman, Chicago, was the guest speaker for the occasion. The doctor, who is head of the surgery department at Loyola University School of Medicine, discussed "Surgical Treatment of Massive Hemorrhage in the Peritoneal Cavity."

Manitowoc

Dr. James M. Sullivan, Milwaukee, addressed the January 29 meeting of the Manitowoc County Medical Society, held at Wellhoefer's Sea Grill in Manitowoc. His subject was "Gallbladder Disease." During the business session an open discussion was held on the proposed changes in the Medical Practice Act. The society went on record as favoring the changes recommended by the Council and officers of the State Society.

Marinette–Florence

Members of the Marinette–Florence County Medical Society met recently to elect the following officers for 1953:

President—*Dr. J. W. Boren*, Marinette
Vice-President—*Dr. K. J. Moss*, Marinette
Secretary—*Dr. R. J. Rogers*, Oconto
Delegate—*Dr. C. E. Koepp*, Marinette
Alternate—*Dr. K. G. Pinegar*, Marinette

Racine

The scientific portion of the January 15 meeting of the Racine County Medical Society featured two guest speakers. Dr. E. T. McEnery, Chicago, and *Dr. Shimpei Sakaguchi*, Milwaukee, addressed the members at the Racine Country Club in Racine. "Pulmonary Conditions in Children" was the title of Doctor McEnery's talk; and Doctor Sakaguchi chose "Intestinal Surgery in Children" as his subject.

Richland

When the Richland County Medical Society met on January 7 at the Park Hotel in Richland Center, *Dr. Ovid O. Meyer* of Madison was the guest speaker. Doctor Meyer, who is chairman of the

Truly
broad-spectrum
therapy in
each tasty
teaspoonful

CRYSTALLINE
Terramycin
BRAND OF OXYTETRACYCLINE. AMPHOTERIC

oral suspension

Pure, well-tolerated Terramycin in pleasant raspberry-flavored vehicle.

Each 5 cc. teaspoonful supplies 250 mg. of truly broad-spectrum antibiotic effective against gram-positive and gram-negative bacteria, including the important coli-aerogenes group, rickettsiae, certain large viruses and protozoan organisms.

Don't miss Pfizer Spectrum appearing regularly in the J.A.M.A.

Pfizer *world's largest producer of antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

department of medicine of the University of Wisconsin Medical School, spoke on the "Diagnosis and Treatment of Leukemias and Lymphomas."

Shawano

Dr. J. J. Mulvaney, Clintonville, was the speaker at the January 21 meeting of the Shawano County Medical Society. The doctor spoke on the practice of psychiatry as it applies to the Shawano area. The talk by Doctor Mulvaney followed a dinner.

Trempealeau–Jackson–Buffalo

Dr. C. O. Rogne, Ettrick, and *Dr. O. M. Schneider*, Blair, were hosts on January 13 to members of the Trempealeau–Jackson–Buffalo County Medical Society and its auxiliary at a dinner held at the Club Midway in Independence. The scientific portion of the meeting was devoted to talks on "The Non-Functioning Gallbladder," which were presented by *Drs. P. V. Hulick* and *G. I. Uhrich*, both of La Crosse.

Winnebago

"The Medical Aspects of the Rh Factor" was the title of a talk presented by Dr. Israel Davidsohn, Chicago, at the January 8 meeting of the Winnebago County Medical Society. Meeting with members of the society in Menasha at the Hotel Menasha, Doctor Davidsohn announced the finding of a new individual blood factor. Special guests at this meeting were the technicians from Theda Clark and Mercy hospitals.

Have they been tested on ALLERGIC PATIENTS?

★ When you prescribe hypo-allergenic beauty aids, ask this one question: "Have these cosmetics been clinically tested on allergic patients?" You can depend on it, AR-EX Cosmetics have been clinically tested on allergic patients. Prescribe them by brand name.

AR-EX COSMETICS, INC. 1036 W. Van Buren St. • Chicago 7, Ill.

AR-EX HYPO-ALLERGENIC COSMETICS

CLINICALLY TESTED FOR ALLERGIC PATIENTS

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

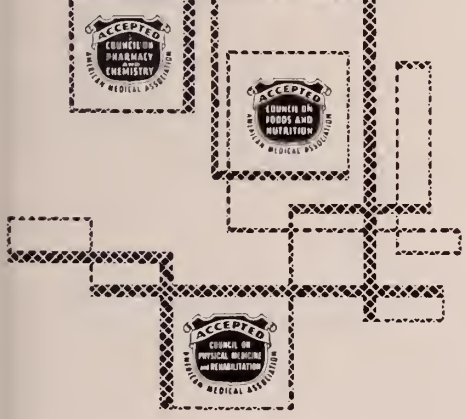
MEDICAL STAFF

William L. Herner, M. D., Medical Director

Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

It is PRICELESS yet, FREE

YES, the A. M. A. Council Seal is awarded without payment of any fee or obligation to advertise.



The manufacturers submit their products on a purely voluntary basis. The evidence is reviewed—the claims are checked—the chemical laboratory makes the necessary tests and the results are examined by a critical group of physicians in various fields of medicine.

If the product is found satisfactory and necessary conditions are met, it is awarded Council Acceptance. This intensive examination by the Council is made without fee from the manufacturer—there is no payment of any sort made. The Council's actions are based on purely the available evidence—not any financial consideration.

If anyone tells you "they cannot afford Council Acceptance for their product," you can discount it 100%—the chances are that members of his firm are not familiar with Council Rules or Standards, or did not realize that the product could be acceptable to the Council.

This is one of a series of advertisements designed to explain the Councils' functions to you.

Prescribe Journal-advertised products and you prescribe the best.

News Items and Personals

Dr. W. J. Smiles Joins Father in Practice

Dr. William J. Smiles, who has completed three years of postgraduate training in internal medicine and cardiology, has moved to Ashland to become associated in practice with his father, *Dr. C. J. Smiles*, and with *Drs. F. D. Weeks, W. E. Bargholtz*, and *J. E. Kreher*. Dr. William Smiles is a 1948 graduate of the University of Wisconsin Medical School and received his postgraduate training in internal medicine as a resident at the Veterans Administration Hospital, Wood.

Doctor Morneau Heads Medical Staff

At the annual meeting of the medical staff of the Clintonville Community Hospital, held on January 13, *Dr. LeRoy F. Morneau*, Bear Creek, was elected president. Other officers elected include *Dr. Owen Larson*, vice president, and *Dr. William C. Arnold*, secretary-treasurer, both of Clintonville.

Health Officer Discusses Services

Dr. G. M. Shinners, health officer of District 6 of the State Board of Health, was the guest speaker at a recent meeting of the Green Bay chapter of the League of Women Voters. He explained health services for the Green Bay area through the levels of state, county, city, and township.

Four Physicians Locate in La Crosse

The addition of four new members to the staff of the Gundersen Clinic and Lutheran Hospital, La Crosse, was announced recently. The four physicians are Drs. J. L. Jaeck, *Thomas Rutter*, K. O. Ghormley, and Robert B. Rasmus.

Doctor Jaeck graduated from the University of Minnesota in the class of 1937. He is a certified specialist in pathology and laboratory procedures, having served a three year residency in pathology at the Veterans Administration Hospital, and the University of Minnesota. He will assume the duties of director of laboratories at the clinic and the hospital.

A certified specialist in surgery, Doctor Rutter was associated with the Jackson Clinic, Madison, during the past year. He is a graduate of Harvard Medical School, and served residencies in his specialty at the Massachusetts General Hospital, Boston; the Jefferson Davis Hospital, Houston; and the Memorial Cancer Hospital, New York City.

Dr. K. O. Ghormley also is a graduate of Harvard Medical School. He interned at the Pennsylvania Hospital, Philadelphia. Following service with the U. S. Navy Medical Corps, he completed a fellowship in urology at the Mayo Clinic. He will be associated with the department of urology at the clinic and hospital.

The fourth member of the group, Doctor Rasmus, is a graduate of the State University of Iowa College of Medicine. He served his residency in internal medicine at the Lutheran Hospital and recently completed two years of service in the U. S. Navy Medical Corps.

Staff Officers Selected at Fond du Lac

Dr. J. C. Devine was elected chief of staff of St. Agnes Hospital, Fond du Lac, at an executive board meeting held on January 15 in the medical library of the hospital. He succeeds *Dr. L. C. Gardner*. Other officers chosen were *Dr. A. M. Hutter*, chairman of the board; *Drs. J. S. Huebner* and *F. J. Cerny*, new members of the board; and *Dr. H. R. Sharpe, Jr.*, secretary.

Burlington Physicians Return to Practice

Two Burlington physicians, *Drs. W. C. Sroka* and *J. D. Van Liere*, have been released from service with the Air Force, and have resumed their practice in partnership in Burlington. Doctor Sroka was released from duty at Vance Air Force Base, Enid, Okla., and Doctor Van Liere from Sheppard Air Force Base, Wichita Falls, Texas.

Dr. and Mrs. Bonner Take Speech Honors

Dr. and Mrs. N. A. Bonner, Manitowoc, were winner and runner-up respectively in the impromptu speech contest conducted at a recent meeting of the Manitowoc chapter of the Dale Carnegie Club. Prior to the talks the contestants drew subjects at random and then were given three minutes in which to prepare the speech.

Doctor Magnin Addresses PTA

Dr. George Magnin, a member of the staff of the Marshfield Clinic, addressed a recent meeting of the Marshfield Parent–Teacher Association. In concluding his talk, the doctor emphasized that fear of the disease is sometimes worse than the disease itself. A question and answer period followed the speech.

Manitowoc Clinic Has New Staff Member

Dr. R. C. Puestow, who has been located at the Veterans Administration Hospital, Hines, Ill., has joined the staff of the Manitowoc Clinic. A graduate of the University of Wisconsin Medical School, he interned at the Graduate Hospital of the University of Pennsylvania and then served two years

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.
Tel. Daly 3021 Milwaukee, Wis.

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Post-Graduate Medical Institution in America)

OBSTETRICS AND GYNECOLOGY

A full time course. In Obstetrics: Lectures, prenatal clinics, witnessing normal and operative deliveries; operative obstetrics (manikin). Gynecology: Lectures; touch clinics; witnessing operations; examination of patients, pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

SURGERY AND ALLIED SUBJECTS

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

WHAT ARE YOUR PLANS FOR HIS FUTURE?

Life Insurance is important to children, too. And here's a plan that provides protection in the amount of $1,000 for children from birth to age 14. It's the Wisconsin Life Junior Estate Plan. A policy for children, at low premium rates, that becomes a grown-up policy at age 21 in the amount of $5.000. Yet the premium remains the same as when the policy was purchased. It's protection for your children that you can easily afford.

Wisconsin Life Insurance Co.
30 W. Mifflin St. Madison, Wis.

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

in the U. S. Army assigned to the Veterans Administration. During the past year and a half he has been assistant to the chief of medicine for heart disease at Hines. The doctor is the brother of *Dr. K. L. Puestow*, professor of medicine at the University of Wisconsin.

Marshfield Hospital Elects Officers

Dr. N. J. Helland, Marshfield, was elected president of the staff of St. Joseph's Hospital, Marshfield, at a meeting of the staff members held on January 27. *Dr. W. A. Olson*, Greenwood, was named vice president, and *Dr. G. S. Custer*, Marshfield, secretary. *Drs. F. J. Gouze* and *K. H. Doege*, Marshfield; and *Dr. G. W. Reis*, Junction City, were named directors of the hospital. About 30 staff members from Marshfield and surrounding communities were guests at the hospital at a dinner which preceded their meeting.

Doctor Olson Joins Clinic Staff

Dr. Merlin J. Olson, who recently was separated from the Air Force after two years as chief of the obstetric and gynecology service at Goodfellow Air Force Base, San Angelo, Texas, has joined the staff of the Monroe Clinic. The doctor graduated from the University of Wisconsin Medical School in 1947 and interned at Southern Pacific Hospital, San Francisco. His postgraduate residency training in his specialty was done at Erlanger Hospital, Chattanooga, Tenn.; St. Luke's Hospital, Spokane, Wash.; and Alexandria Hospital, Alexandria, Va.

Shawano Hospital Holds Election

At the January 21 meeting of the medical staff of Shawano Municipal Hospital, officers were elected to serve during 1953. *Dr. D. A. Jeffries* was elected president to succeed *Dr. H. C. Marsh*. Doctor Jeffries recently returned from U. S. army service and had been stationed at Granite City, Illinois. *Dr. R. R. Rivard* was re-elected vice president of the staff and Dr. Harry Thimke was elected secretary-treasurer to succeed *Dr. J. W. Christofferson*.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Fromm Opens Office in Madison

Dr. Arno H. Fromm, who has been a member of the department of preventive medicine of the University of Wisconsin for the past two years, has opened an office for the practice of internal medicine in Madison. A graduate of Marquette University School of Medicine, Doctor Fromm has taken postgraduate work at Columbia University, New York City, at the University of Minnesota, and at Cook County Hospital in Chicago. He taught anatomy courses at Marquette University for three years following his graduation.

Doctor Feig Addresses Red Cross Group

"Old and New Uses of Gamma Globulin" was the title of a speech by Dr. Milton Feig, Madison, at the midwestern regional Red Cross meeting held on February 3 at the Loraine Hotel in Madison. Doctor Feig is director of the Preventable Disease Section of the State Board of Health and was formerly district health officer of the Green Bay area.

Janesville Physician Appointed Trustee

Dr. M. M. Baumgartner, practicing physician in Janesville since 1930, was appointed a trustee of the American Association of Medical Clinics at the December meeting of the American Medical Association. The Association of Medical Clinics reviews the type of organization and practice of groups and qualifies those justified in the use of the name of clinic. For the past four years, Doctor Baumgartner has served as membership chairman of the association.

Doctor Glover Receives Certification

Dr. B. H. Glover, assistant professor of neuropsychiatry at the University of Wisconsin Medical School, has been certified in psychiatry by the American Board of Neurology and Psychiatry. A graduate of Northwestern University Medical School, Doctor Glover served his internship at the U. S. Naval Hospital, Bremerton, Wash.

Doctor Gunderson Heads Hospital Staff

Dr. R. H. Gunderson was named president of the Beloit Hospital staff when the group recently held its annual meeting. *Dr. Thomas C. Sweeney* was elected vice president, and *Dr. L. P. Brillman,* secretary. *Drs. R. M. Baldwin* and *K. L. Carter* were appointed members of the executive committee. All of the officers are from Beloit.

Madison Has New Pediatrician

Dr. Richard B. Anderson, a native Madisonian, recently announced his association with *Drs. D. M. Britton, J. P. Malec, F. L. Hummer,* and *W. A. Tanner* of Madison. His practice will be limited to pediatrics. A 1947 graduate of the University of Wisconsin Medical School, the doctor served his internship at the University of Oklahoma Hospital. He took postgraduate work in his specialty at the University of Michigan and at the University of Pennsylvania Hospital, Philadelphia.

Doctor Angevine Addresses Missouri Groups

Dr. D. Murray Angevine, professor of pathology at the University of Wisconsin Medical School, was the speaker for the annual guest lecture sponsored by the St. Louis (Missouri) Pathological Society and the St. Louis County Medical Society. He ad-

17–Ketosteroid
Determinations
Quantitative Gonadotrophin
Assays
Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES
5001 West Belt Line Highway
MADISON 5, WISCONSIN

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899
specialized service assures "*know-how*"
MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Daly 8-1021

LIQUID PLASMA

U. S. LICENSE 187

Half pint units of liquid plasma available.
(Recipient set not included.)

Save by ordering directly from:

JUNIOR LEAGUE BLOOD CENTER

763 No. 18th St. Milwaukee 3, Wis.

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

dressed the groups on the subject of "Signficant Factors in the Localization of Infection."

While in St. Louis the doctor also lectured at both Washington University and the St. Louis University schools of medicine. On these occasions his subject was "Connective Tissue and Disease."

Columbia–Marquette–Adams

The February 10 meeting of the Columbia-Marquette–Adams County Medical Society was held in Briggsville at Clark's Dining Room. The program was primarily devoted to business and featured a talk by *Dr. J. W. MacGregor*, Portage, on the new fee schedule.

Dane

At the October 14 meeting of the Board of Trustees of the Dane County Medical Society, the following officers were elected for the 1952–1953 term: *Drs. J. K. Curtis*, president; *S. L. Chase*, president-elect; *S. C. Rogers*, vice president; *G. E. Oosterhous*, secretary; *M. T. Morrison*, Mount Horeb, and *C. L. Ingwell*, Deerfield, trustees; *C. W. Stoops*, *T. A. Leonard*, and *G. C. Hank*, delegates; and *R. F. Collins*, *O. S. Orth*, and *C. A. Fosmark*, alternates. Unless otherwise noted all of the officers are from Madison.

When the society met at the Madison Club on February 12, the guest speaker was Dr. Conrad Elvehjem, dean of the University of Wisconsin Graduate School and professor of biochemistry. His subject was "Nutrition and Its Relation to Tooth and Bone Structure."

Sauk

Dr. Chester M. Kurtz, a member of the department of medicine of the University of Wisconsin Medical School, was the guest speaker at the February 10 dinner meeting of the Sauk County Medical Society. Meeting with the society at the Warren Hotel in Baraboo, Doctor Kurtz discussed "The Newer Developments in Heart Disease."

Doctor and Wife Take Africa Post

Dr. and Mrs. T. F. Meves, a Milwaukee physician and his wife, left for Nigeria, Africa on March 2. They were commissioned as missionaries on February 15 during ceremonies at the Emmaus Lutheran Church. The couple will work at Eket, Nigeria, in a new 75 bed hospital, which was financed largely by a gift from an anonymous Milwaukeean. They will also organize a program of medical mission work in the area.

Doctor Meves is a graduate of the University of Indiana School of Medicine and interned at Milwaukee Hospital. He recently received his discharge from service after two years' duty in Korea. Mrs. Meves is a graduate nurse and formerly worked at Milwaukee Hospital.

Doctor Gute Has Two New Associates

Drs. Robert E. Flood and Raymond A. McCormick recently became associated in general practice with *Dr. E. B. Gute* of Whitefish Bay. Both of the new physicians are graduates of Marquette University School of Medicine.

After completing his internship at St. Mary's Hospital, Doctor Flood served for two years as a medical officer in the European theater. He was a resident at the Woman's Hospital in New York City in 1951, and more recently he has been resident physician at St. Mary's Hospital in Milwaukee.

Doctor McCormick received his medical degree in 1951 and served a rotating internship at St. Mary's Hospital. Both he and Doctor Flood have worked as part-time medical consultants at the Southern Wisconsin Colony and Training School at Union Grove.

Doctor Sullivan Addresses Nebraskan Group

Dr. J. M. Sullivan, Milwaukee surgeon, was the guest speaker at the January 7 meeting of the Lancaster (Nebraska) County Medical Society. The subject of his paper was "Diseases of the Veins." Doctor Sullivan is editorial director of the Journal and chairman of the State Society's Committee on Public Policy.

Doctor Kearns Heads Hospital Staff

Dr. Walter M. Kearns was named president of staff of the Milwaukee County General Hospital at the annual medical staff meeting held on February 5. He succeeds *Dr. M. C. F. Lindert. Dr. Bruno J. Peters* was named vice president and *Dr. Leonard S. Markson* is the new secretary-treasurer.

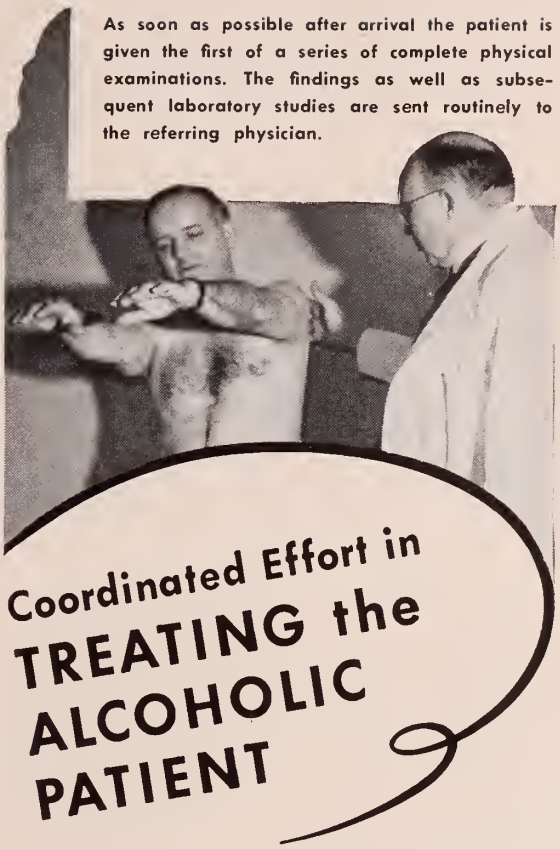
Doctor Peterman Gives Talks

Dr. M. G. Peterman, a Milwaukee pediatrician, was one of the speakers who took part in the scientific sessions of the December meeting of the American Medical Association which was held in Denver. The subject of his address was "The Behavior of Epileptic Children."

On December 10, Doctor Peterman was guest speaker for a meeting of the Texas Pediatric Society in Port Arthur, and later in the week he presented a paper at the University of Texas Medical School in Galveston. Late in January the doctor addressed a meeting of the Louisiana Pediatric Society and the annual meeting of the Arkansas-Louisiana–Texas Academy of Medicine.

Milwaukee

The guest speaker for the January 8 meeting of the Medical Society of Milwaukee County was a Canadian physician, Dr. Bram Rose of Montreal. Doctor Rose is an associate physician at the Royal Victoria Hospital and associate professor of medi-



The system of therapy at The Keeley Institute is aimed (1) at overcoming the *acute attack* of alcoholism; restoring the patient's well-being, and (2) through group and individual re-education attaining a condition of *permanent sobriety.*

At all times the regimen of treatment is well coordinated under the direction of a staff of experienced full-time physicians who are members of the American Medical Association.

When you refer a patient to The Keeley Institute, you know that he will be taken care of as your patient and you are continually informed of his progress.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

cine at McGill University Faculty of Medicine. He also is a consultant in allergy at the Queen Mary Veterans' Hospital. The doctor discussed ACTH and cortisone in the treatment of allergic diseases.

Milwaukee Academy of Medicine

Dr. E. C. Welsh presented his paper, which won first prize in the annual Rogers Memorial Essay Contest, at the February 17 meeting of the Milwaukee Academy of Medicine. The title of the paper was "Rehabilitation of the Hemiplegic Patient."

The Arthur W. Rogers Memorial Lecture was presented this year by Dr. Wilder G. Penfield, professor of neurology and neurosurgery at McGill University Faculty of Medicine. The doctor's subject was "Obstetrical Cause and Surgical Treatment of Temporal Lobe Epilepsy."

Milwaukee Oto–Ophthalmic Society

The January meeting of the Milwaukee Oto-Ophthalmic Society was held at the Milwaukee University Club on the 27th. The program, which was prepared by the staff of Children's Hospital, included a discussion by *Dr. Thomas Tolan* on "The Hearing Program for Children in Milwaukee;" and case presentations by Drs. W. E. Scheunemann, *Arvid Holm*, and *S. S. Blankstein*.

SOCIETY RECORDS

New Members

W. H. Dornette, 1300 University Avenue, Madison.

Ann Bardeen, 1300 University Avenue, Madison.

P. M. Arnesen, Columbia Hospital, Milwaukee.

B. B. Becker, 238 West Wisconsin Avenue, Milwaukee.

J. W. Callahan, 3730 West Hampton Avenue, Milwaukee.

Joseph Himes, 4920 West Good Hope Road, Milwaukee.

L. M. Rosenheimer, St. Michael's Hospital, Milwaukee.

P. R. Savino, 836 North Twenty-Fourth Street, Milwaukee.

G. A. Stokdyk, 8320 West Bluemound Road, Wauwatosa.

E. H. Tashkin, 2200 North Third Street, Milwaukee.

G. W. Hilliard, Jr., 325 West North Avenue, Milwaukee.

C. D. Jurss, 2011 West Capitol Drive, Milwaukee.

J. F. Wepfer, St. Joseph's Hospital, Milwaukee.

G. F. Burgess, Jr., 2416 East Newton Avenue, Milwaukee.

A. J. Grueninger, 3443 North Murray Avenue, Milwaukee.

A. F. Rodenbeck, 2236 East Holt Avenue, Milwaukee.

D. K. Schmidt, 3612 North Green Bay Avenue, Milwaukee.

W. L. McLane, Gilman.

Changes in Address

Thomas Rutter, Madison to Gundersen Clinic, La Crosse.

O. Edward Ogilvie,* Wood to 916 Military Drive, Salt Lake City, Utah.

E. S. Huston,* Milwaukee to 1708 Rainier, Bremerton, Washington.

G. V. Muscato, Jr.* Lockport, New York to Pediatric Section, U. S. Army Hospital, Fort Campbell, Kentucky.

R. K. Salter,* Newburg to 2609 Grant Avenue, El Paso, Texas.

A. A. Bullock, Jr., Wood to North Louisiana Clinic, 1130 Louisiana Avenue, Shreveport, Louisiana.

H. J. Kanin, San Antonio, Texas to 3453 North Fifty-Seventh Street, Milwaukee.

R. J. Krill, Wauwatosa to 5030 Willows Avenue, Philadelphia, Pennsylvania.

J. J. Mueller, Madison to 2174 North 63rd Street, Milwaukee.

C. A. Pardee, Appleton to 2115 Wales Drive, Fort Myers, Florida.

C. J. O'Neill, Manitowoc to 322 South Scoville, Oak Park, Illinois.

R. H. Pfeifer, Clintonville to 1761 F Valley View, Birmingham, Alabama.

W. C. Sroka, Enid, Oklahoma to Garvey Building, Chestnut Street, Burlington.

J. D. Van Liere, Wichita Falls, Texas to Garvey Building, Chestnut Street, Burlington.

E. F. Brandt,* Wood to 0992058, 97th General Hospital, APO 757, c/o Postmaster, New York, New York.

A. E. Cowle,* Madison to U. S. Naval Hospital, Medical Corps, Great Lakes, Illinois.

G. H. Lohrman,* Oconomowoc to Nurnberg, Germany.

G. P. Nichols, Statesan to 4001 Winnemac Avenue, Madison.

Katherine E. Stewart, Madison to 213 Garfield Avenue, Eau Claire.

D. W. Curtin, Little Chute to 314 Kimberly Avenue, Kimberly.

D. R. Peterson, Strum to Krohn Clinic, Black River Falls.

R. C. Thackeray, Winnebago to 1142 Douglas Avenue, Racine.

J. A. Buesseler, Springfield, Ohio to 213 South Charter Street, Madison.

H. E. Breckenridge, Waupaca to 109 West Church, Blackwood, New Jersey.

Helen P. Davis, Madison to 3337 East Mitchell Drive, Phoenix, Arizona.

R. E. Schmidt, Smyrna, Tennessee to 312 East Wisconsin Avenue, Milwaukee.

H. O. Zurheide, Milwaukee to Elm Grove, Wisconsin.

J. V. Bolger, Milwaukee to 102 East Main Street, Waukesha.

I. M. Becker, Milwaukee to 3 C—2045 Walnut Street, Philadelphia, Pennsylvania.

W. L. Coon, Milwaukee to 3548 Roselawn Avenue, Glendale, California.

C. L. Junkerman,* Yokosuka, Japan to U. S. Naval Hospital, Great Lakes, Illinois.

G. E. Fox,* New York, New York to Forest City, Iowa.

T. J. Beno,* Fort Riley, Kansas to 1917 Willow Street, Green Bay.

M. S. LeTellier,* Astoria, Oregon to Medical Field Service School, Brook Army Medical Center, Fort Sam Houston, Texas.

C. E. Lindemann,* Camp McCoy to 5021 Army Service Unit, Fort Riley, Kansas.

W. K. McCreary,* Buckley Field, Colorado to 50 Medical Group, Clovis Air Force Base, Clovis, New Mexico.

J. G. Frisch,* Randolph Air Force Base, Texas to R. F. D. 2, c/o Kenneth Christopher, Seneca Falls, New York.

P. J. Lawler,* Milwaukee to U. S. Penitentiary Hospital, Lewisburg, Pennsylvania.

L. P. Wolf,* Milwaukee to 1117th Army Service Unit, U. S. Army Hospital, Fort Belvoir, Virginia.

E. H. Schalmo,* Milwaukee to U. S. Army Hospital, Camp Breckenridge, Kentucky.

W. T. Russell,* Chamblee, Georgia to 228 West Main Street, Sun Prairie.

L. R. Pfeiffer, Cumberland to Turtle Lake.

R. G. Knight, San Francisco, California to 244 East Main Street, Reedsburg.

A. E. Leiser,* Monroe to 1st Aero Medical Group, Donaoldson Air Force Base, Greenville, South Carolina.

T. V. Beutler, La Crosse to 4506 Standish Drive, Fort Wayne, Indiana.

M. E. Barnes, Jr., Madison to 335 South Franklin Street, Wilkes–Barre, Pennsylvania.

N. J. Kozokoff,* San Antonio, Texas to 02097323, Hdqts. 10th Field Artillery, B. U., Med. Det., 3rd Inf. Div. APO 468, c/o Postmaster, San Francisco, California.

Ann A. Cinelis, Sheboygan to Krohn Clinic, Black River Falls.

J. N. Shanberge, Milwaukee to Veterans Administration Center, Wood.

J. R. Evrard,* Fox Point to Building 1109 U. S. Naval Training Center, Great Lakes, Illinois.

A. E. Schultz, Victorville, California to Route 1, Box 155, Birnamwood, c/o Otto W. Schultz.

---

* Military Service.

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

Prescribe Journal-advertised products and you prescribe the best.

Prescription Perfect

RED LABEL • BLACK LABEL

Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.

Born 1820 . . . still going strong

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

DEATHS

Dr. Oscar Lotz, who died on January 15, 1953, spent some 35 years of his life, simultaneously, in two fields of medical service. He practiced in Milwaukee for about 40 years and served on the staff of the Wisconsin Anti-Tuberculosis Association from 1917 until 1951. During the last 12 years, he was its executive secretary.

Born in Milwaukee on June 23, 1880, Doctor Lotz received his doctor of medicine degree at the University of Pennsylvania in 1905. After an internship at Mercy Hospital, Pittsburgh, and a residency at Johnston Emergency Hospital, Milwaukee, he began practice in Milwaukee in 1907 and continued until the demands of his public health responsibilities made necessary his retirement. During most of these years he was a member of the staff of Columbia Hospital, Milwaukee, and an attending physician or consultant to Children's Hospital, Milwaukee. At various times he was a consultant to the Rocky Knoll Sanatorium, Plymouth; Sunny View, Winnebago; and Maple Crest, Manitowoc.

An early interest in tuberculosis brought Doctor Lotz into close association with Dr. Hoyt E. Dearholt, founder and first executive secretary of the Wisconsin Anti-Tuberculosis Association. A medical adviser of the Association in early years, Doctor Lotz was chairman of the Medical Board of Review for draft rejectees in 1917. Because of the high tuberculosis findings revealed, the Association set up its traveling chest clinics in the summer of 1919.

When Doctor Dearholt died in 1939, Doctor Lotz was named his successor as executive secretary by the Association's board of directors. His 12 years as the Association's executive head were marked by grants to both medical schools in the state for medical research and training, the establishment of "Dearholt Days" for the medical teaching of tuberculosis, and many postgraduate courses for physicians in practice. The Association became the first state tuberculosis association to put a chest x-ray bus on the highways. Wisconsin adopted a model "free care" law for the hospitalization of active cases, and rehabilitation services were provided for every Wisconsin sanatorium.

Doctor Lotz was first vice-president of the State Medical Society of Wisconsin in 1918, president of the State Board of Medical Examiners in 1922, president of the Milwaukee Academy of Medicine in 1924, vice-president of the Mississippi Valley Trudeau Society in 1944, and president of the Mississippi Valley Conference on Tuberculosis in 1948. He also served on the boards of many health and welfare organizations. He was a member of the Medical Society of Milwaukee County and the State Medical Society, the American, Mississippi Valley and Wisconsin Trudeau societies and the Milwaukee Academy of Medicine, and was a diplomate of the American Board of Internal Medicine. He was a Fellow of the American Medical Association and American College of Physicians.

A natural teacher, Doctor Lotz was frequently called upon to speak on tuberculosis control and related subjects before students in nursing, occupational therapy, and social work, as well as before lay audiences. He had a gift of homely illustration and simple phraseology which endeared him to lay audiences.

Doctor Lotz was married to Gertrude Knowlton on April 18, 1918. He is survived by Mrs. Lotz and two daughters, Mrs. Robert W. Fraser–Lee, Port Huron, Michigan, and Mrs. Charles F. Donnelly, Forestville, Virginia.

(*Prepared by Mr. Harold Holand of the Wisconsin Anti-Tuberculosis Association.*)

Dr. George E. Hoyt, Menomonee Falls physician, died on January 16 at his home following a long illness. He was 91 years old.

Born in Menomonee Falls on August 13, 1861, he was the son of Dr. and Mrs. William M. Hoyt, both of whom were practicing physicians. The doctor received his medical degree at Northwestern University Medical School in 1892 and served internships at Mercy and Alexian hospitals, Chicago. He then joined his widowed mother in the practice of medicine in Menomonee Falls.

In 1909 Doctor Hoyt served in the state assembly and in 1911 and 1913 served in the senate. He was appointed deputy state health officer in 1914, assigned to the southeast area of the state exclusive of Milwaukee. He held this position until 1944 when he retired at the age of 82.

A past president of the Waukesha County Historical Society, the doctor's professional affiliations included the Waukesha County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by a nephew and a niece.

Dr. Austin O. Olmsted, 72, practicing physician and community leader of Green Bay for more than 50 years, died on January 14 in a Green Bay hospital following a short illness. He was born in Green Bay on January 1, 1881.

Following graduation from the Hahnemann Medical College and Hospital, Chicago, the doctor became associated with his father, Dr. Austin F. Olmsted, in the practice of general medicine in Green Bay. In 1920 he began to specialize in radium and x-ray therapy.

Doctor Olmsted participated with great energy in a long list of civic activities, including serving as president of the Green Bay board of education for many years. He was a former president of the Brown–Kewaunee–Door County Medical Society, a member of the Fifty Year Club of the State Medical Society, and a member of the American Radium Society, the Radiological Society of North America, and the American Medical Association.

Surviving are his wife and two daughters.

Dr. Philip W. Smith, Black Creek physician, died on January 20 in a New London hospital as a result

Knox Gelatine... useful protein supplement in health and disease

Necessary for Nitrogen Balance

Good dietary practice admits of an optimum protein intake of about 100 grams per day with a minimum of not less than 1 gram per kilo of body weight. At least half of the protein should be of first class biologic value, the remainder furnished in a readily assimilable form the 14 or more synthesizable amino acids necessary for nitrogen balance.

Excess Protein Assured

Since large amounts of whole protein are necessary to assure a margin of safety for varied metabolic needs, an excess of protein intake is assured through the use of Knox Gelatine Drink daily. One envelope of Knox Gelatine readily prepared with fruit juice, water or milk, as the patient desires, provides 7 grams of gelatine of which 85 per cent is pure protein.

For Optimal Health

Since protein is not stored in the body, the daily catabolic needs and any extraordinary requirements must be taken care of daily, in order to assure optimal health.

Glycine and Proline Important

Knox Gelatine is a valuable protein supplement, easy to digest and administer as well as being non-allergenic. Knox Gelatine contains important glycine and proline necessary for hemoglobin formation. It has a high specific dynamic action, spares essential amino acids and furnishes amino acids for the continuous dynamic exchange of nitrogen in the tissues.[1]

1 Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

You are invited... to send for brochures on diets of Diabetes, Colitis, Peptic Ulcer . . . Low Salt, Reducing, Liquid and Soft Diets.
KNOX GELATINE, JOHNSTOWN, N.Y., DEPT. W.S.

Available at grocery stores in 4-envelope family size and 32-envelope economy size packages.

KNOX GELATINE U. S. P.
All Protein No Sugar

of injuries suffered in an automobile accident on January 8. He was 39 years old.

Born in Racine on May 3, 1913, the doctor attended Marquette University, took his pre-medical training at St. Mary College, Winona, Minn., and received his medical degree from the University of Wisconsin Medical School in 1937. He interned at Milwaukee Hospital and served a surgical residency at the Grace Hospital, Welch, West Virginia.

Doctor Smith served with the Army Medical Corps during World War II, and following his discharge in May 1946, he opened an office for the practice of medicine in Black Creek. He was on the staff of the St. Elizabeth Hospital, Appleton, and was a member of the Outagamie County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his wife, three daughters, and a son.

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2611 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.
FOUR STORES
Complete Stocks Of Medical Specialties
Orders Filled Promptly

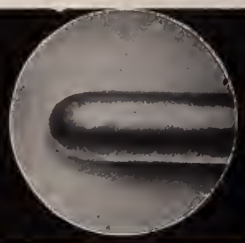
PHYSICIAN AND HOSPITAL SUPPLIES

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

RADON SEEDS



FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

THE RADIUM EMANATION CORPORATION
GRAYBAR BLDG. Telephone MU 3-8636 NEW YORK, N. Y.

today's health a must!

for your reception room

Physicians' Half-Price Rates

4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

BUY
UNITED STATES
DEFENSE BONDS

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

The institution is located on Oconomowoc Lake, two miles east of Oconomowoc and 28 miles west of Milwaukee on U.S. Highway 16.

There are 25 acres of landscaped grounds and all the buildings for patients are fireproof.

Senile — Convalescent — Nervous

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

For further information write or phone
G. R. Love, M. D.
Physician in Charge
Oconomowoc, Wis.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Complete office equipment of General Practitioner which includes examining table, instrument and drug cabinets, steel filing cabinet, sterilizer, scales, microscope, desk, chairs, book cases, etc., all in excellent condition. Doctor retiring because of ill health. Address replies to Dr. Edward Jackson, 931 W. Walnut St., Milwaukee, Wis. Phone Lo. 2–5144.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

FOR SALE: Complete office equipment and library of deceased physician. For further information write to box 472 in care of the Journal.

FOR RENT: Desirable office space, consisting of 2 large treatment rooms, spacious furnished waiting room. Will share lab. Air conditioned building in new heavily populated area. Partly occupied by general physician and dentist. Write Maurice Olsen, M.D., 7623 W. Burleigh, Milwaukee 10, Wis.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE by retired physician, Fischer diathermy machine, Miller short wave machine, and McIntosh polysine generator. Best offer accepted. Write or call Dr. E. M. Rice, 1738 Alta Vista Ave., Wauwatosa 13, Wis. Phone Bl. 8–2300.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

WANTED, oto-laryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2–8118.

WANTED: Used hospital size Bovie Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5–9100.

FOR SALE: Two metal, chrome and white, treatment chairs and stools. Adjustable backs, head rests, seats, and arms. Write Mrs. W. F. Krueger, 2473 N. 84th St., Wauwatosa, Wis., or call Greenfield 6–3517.

FOR SALE: Complete eye, ear, nose, and throat equipment, including all surgical, diagnostic, and refracting instruments. Make an offer for quick sale. Address replies to Mrs. D. G. Hugo, 508 Washington Blvd., Oshkosh, Wis.

FOR SALE: Practice of the late Dr. J. J. Fitzgerald, Eagle, Wis. Beautiful modern home, office in residency with separate entrance. No competition. Physician badly needed. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

WANTED: Physician as an associate in general practice, preferably with surgical training and service exempt. City of 10,000 population in north central Wisconsin, with excellent hospital facilities and on a salary basis with eventual partnership. Address replies to box 473 in care of the Journal.

FOR SALE: Optometric equipment in good location for a physician who does refraction. Equipment valued at $600. Address replies to box 474 in care of the Journal.

WANTED: Pediatrician, or general practitioner willing to do large share of pediatrics, in an active group practice in suburban Milwaukee. Address replies to box 475 in care of the Journal.

GENERAL PRACTITIONER, middle-aged with extensive experience, desires association or location. Available about June 1, 1953. Address replies to box 476 in care of the Journal.

PHYSICIAN WANTED, preferably one with one or two years experience in private practice, as an associate in a well established general and surgical practice in a city of over 30,000. Address replies to box 478 in care of the Journal.

E.E.N.T. PRACTICE FOR SALE: Twenty year location, income considered very large, and collections 96 per cent. Cultural, social activities, and schools are very fine. Price $8,000, divided over period of three years. Population 15,000, suburbs 6,000, and drawing around 50,000. Sports include skiing, muskies, golf, and hunting. Optional purchase may include $50,000 four bedroom, three bath, beautiful home for $25,000. Address replies to box 480 in care of the Journal.

LOCATION WANTED: General practitioner, age 28, married, family, desires assistantship, association, or location. Completing 24 months active duty in Army on April 1. Licensed in Wisconsin. Graduate of U. of Wisconsin Medical School. Has own office furniture and equipment. Address replies to box 481 in care of the Journal.

WANTED: Associate in general practice in a community of 30,000. Internist or well trained G.P. Percentage basis. Address replies to box 482 in care of the Journal.

ASSOCIATION WANTED in general practice. Graduate Washington U. School of Medicine, 1951; 1 year rotating internship; 1 year pediatrics; 27 years old, married; priority IV. Address replies to P. L. Wachtel, M. D., St. Louis City Hospital, St. Louis, Mo.

Wanted RESIDENT PHYSICIAN: Large Institution for Mentally Deficient located in nice residential section of thriving city of 140,000. Practice can be limited to General Medical Services but there is opportunity for experience in Pediatrics and moderate amount of Surgery. Good salary, liberal time off for week ends, holidays, sick leaves, and vacations with full pay. Full maintenance for man and wife. (Quarters not available for children at this time.) Night work at a minimum. Moderate physical handicaps no bar to employment. Address replies to Superintendent, Fort Wayne State School, Fort Wayne 1, Ind.

ASSOCIATION WANTED: Physician who is tired of solo practice desires association with physician or group to do general practice. Address replies to box 483 in care of the Journal.

POSITION OPEN for associate interested in obstetrics and general practice in a clinic. Substantial retirement program and opportunity to become member of association without "buying in." Salary open. Facilities of two hospitals available. Address replies to box 484 in care of the Journal.

FOR SALE: Electro Hemometer with two cells and two pipets. Instrument like new. Price $45. Address replies to C. F. Ulrich, 625 57th St., Kenosha, Wis.

POSITION OPEN for physician on a locum tenens basis for a period of a year or two in a clinic. Salary open. Facilities of two hospitals available. Address replies to box 485 in care of the Journal.

HOUSE DOCTOR WANTED: Eight hours daily, afternoons and evenings; $350 to $400 monthly. Write or phone J. P. Nothum, Doctors Hospital, 2711 W. Wells St., Milwaukee, Wis. Phone DI 2–9310.

FOR SALE OR LEASE: Medical building in Marinette, Wis. Available Sept. 1, 1953. For information write H. L. Jorgenson, M. D., 8163 N. E. Second Ave., Miami, Fla.

WANTED: Medical technologist, registered. Opportunities for research and advancement. Very pleasant working conditions. Thirty-five hour week Address replies to Junior League Blood Center, 763 North 18th St., Milwaukee, Wis.

535 North Dearborn Street, Chicago 10, Illinois

AMERICAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

MARCH, 1953

Current Action on Doctor Draft

Since the AMA's December meeting, the Department of Defense and the Armed Services have taken steps to revise Public Law 779, the "doctor draft law." Recommended revisions incorporated in a new draft law were approved by the Armed Forces Medical Policy Council (AFMPC) and forwarded to the Office of the Secretary of Defense for coordination with military departments. Until agreement has been reached within the Department, contents of the new bill will not be announced.

The new measure presumably will abolish the present categories and classify registrants into two groups: (1) All persons who did not serve in the armed forces during World War II—youngest to be called first; (2) Persons who have served—those with least amount of service to be called first. Also, the bill would provide that special registrants now classified in priorities I and II would be inducted when they became available for duty. Persons who have served on active duty for 12 months or more subsequent to June 25, 1950, would not be liable for further military service.

Other AMA recommendations which have been acted upon by the Armed Forces Medical Policy Council:

(1) Thorough study of dependent medical care—although a study is warranted, AFMPC reports that further action must be taken by the new Secretary of Defense.

(2) Study of percentage of physician's time spent in treating other than military personnel—study currently is under way.

(3) Revision of physical requirements for physicians being examined for military service—the Department of Defense adopted a new policy which will consider all physicians potentially acceptable for military service provided they can be reasonably productive in the armed forces. Military departments have been directed to re-evaluate physicians previously disqualified. Approximately 2,600 physicians in priorities I and II will be re-examined.

SAMA Sets '53 Program in Motion

Strengthening its position as the voice of its 15,000 members, the House of Delegates of the Student American Medical Association set an accelerated program in motion during its second annual convention in December in Chicago.

Chief proposal of the delegates from 50 of SAMA's 59 chapters called for a point system in doctor draft legislation to consider all previous military service, regardless of branch or rank. Another resolution asked for a synchronization of doctor draft calls with hospital training programs so that young doctors will not experience unnecessary delay in resumption of their training following military service. The House also urged its constituent chapters to invite officers and staff members from organized medicine to address local meetings so that students will be kept informed on current medical activities.

The convention, the last to be held in December, attracted more than 225 delegates, alternates, and guests. The next convention is scheduled for June.

Keep Plugging "Your Doctor" Film

Local medical societies can improve their "public relations rating" in the community by booking the "Your Doctor" film for non-theatrical showings at society meetings or to PTAs, schools, churches, and other groups interested in health. Sixteen millimeter prints of this 15-minute sound film now are available on loan from Modern Talking Picture Service, Inc., 45 Rockefeller Plaza, New York 20, N.Y. Produced as a documentary, this film points up ways in which the medical profession has helped to bring better medical care to everyone. During 1952 more than 12 million Americans viewed the movie in over 5,000 commercial theaters throughout the country. It is hoped that medical societies will continue to promote the film locally.

AMA Conference on Special Health Services in Industry

Current trends in direct service plans (health services in industry provided through salaried or panel physicians) . . . ways and means of maintaining high standards of medical service directly to certain groups of industrial workers . . . were aired at an informal Conference on Direct Service Plans. This meeting, sponsored by the Committee on Medical Care for Industrial Workers—a joint committee of the AMA's Council on Medical Service and the Council on Industrial Health—was held in January during the Annual Congress on Industrial Health.

Viewpoints of labor, management, and the medical profession were expressed as more than 50 representatives of plans sponsored by labor and industry sat down with representatives of state and county medical societies. Many suggestions regarding future developments in programs designed to render medical care through voluntary methods were presented for study and future discussion.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors -- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- F. J. Mellencamp, Milwaukee
Secretary ---------- E. H. Pawsat, Fond du Lac
Vice-chairman ------- N. L. Low, Racine
Delegate ---------- K. B. McDonough, Madison
Alternate ---------- K. J. Winters, Wauwatosa

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	12
American Meat Institute	18
Ames Company, Inc.	6
Ar-Ex Cosmetics	30
Audiophone Utilities	36
Ayerst, McKenna & Harrison, Ltd.	20
Barr X-Ray Company	33
The Bayer Company	13
Benson Optical Company	4
Bergmann Prescription Center	25
Camel Cigarettes	10
Canada Dry	40
Central Drug	25
Cook County Graduate School of Medicine	5
Doerflingers	43
Endocrine Laboratories	35
Hotel Schroeder	5
House of Bidwell	36
Hurley X-Ray Company	34
Junior League Blood Center	36
Keeley Institute	37
Kennedy–Mansfield	25
Knox Gelatin	41
Lakeside Laboratories	9
Lederle Laboratories	facing page 18
Lilly, Eli and Company	22
Mallard, Incorporated	21
Mallatt Pharmacy	25
Mather Pharmacy	25
Mayer Drug	25
Mead Johnson and Company	49
Medical Protective Company	35
Merck and Co.	19
Milwaukee Sanitarium	50
New York Polyclinic	33
Orthopedic Appliance Company	33
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	29
Philip Morris	16
Physicians Casualty Association	39
Physicians and Hospitals Supply Co.	14
Professional Business Service	195
Q-Test Distributor of Minneapolis	7
Radium Emanation Corporation	42
Rennebohm's	25
Rogers Memorial Sanitarium	50
Sacred Heart Sanitarium	30
St. Croixdale Sanitarium	5
Schering	15
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	33
Stanley, Inc.	42
Summit Hospital	43
Time Insurance Company	193
Upjohn Company	11
Winthrop–Stearns, Inc.	17
Wisconsin Life Insurance Company	34
Wyeth	8

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron–Washburn–Sawyer–Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia–Marquette–Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake–Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	H. W. Harris Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	R. S. Galgano Delevan	K. C. Bill Elkhorn	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 APRIL 1953 Number 4

Lumbar Hernia

A Case Report from Mercy Hospital, Janesville

By VINCENT W. KOCH, M. D., F. A. C. P.; RAYMOND C. GALLAGHER, JR., M. D.; WAYNE A. MUNN, M. D., F. A. C. S.; and CAROL TOMLINSON, M. D., A. C. R.

THE occurrence of a hernia in the lumbar region is one of the rarer varieties of hernia. Only 115 cases have been reported in the medical literature. A lumbar hernia may occur as a congenital affection, spontaneously, or as a result of severe local injuries or lowered resistance following infectious processes. The case to be reported in this paper is an example of a lumbar hernia caused by direct trauma.

Historical

In Pierre Franco's work on hernias, "Traite des hernies," published in 1561, no mention is made of a lumbar hernia, and it was not until 1672 that the possibility of this type of hernia was suspected. At this time Paul Barbette suggested that "the peritoneum may rupture at its posterior aspect toward the back, thus forming a hernia." Subsequently many writers (Blancard, 1701; Dolee, 1703; Bludgeon, 1728) alluded to lumbar hernia, but no trustworthy observation was recorded until 1731 when Garangeot described a case of strangulated hernia reducible after death.

Garangeot's report, however, failed to stimulate much interest among his contemporaries, and only brief reports appeared in the literature. In 1774 Petit described the triangle which bears his name, but Jeannel and Baron Larrey, both writing on the subject, state that Petit had written no more fully than the other early authors and that there was no more reason to call this region "Petit's Triangle" than to identify it with the name of Dolee, Garangeot, Ravation, or Balin.

No serious study was given to the subject of lumbar hernia until Grynfeldt in 1866 described in detail the space which bears his name. Four years later, in 1870, Lesshaft came to the same conclusions. These papers emphasized this space as an important factor in the occurrence of lumbar hernia, as the Grynfeldt-Lesshaft space is larger and more constant than the triangle of Petit.

Anatomy

A lumbar hernia may occur anywhere in the lumbar region, which is an area bounded above by the twelfth rib, below by the crest of the ilium, in front by a line drawn vertically downward from the anterior extremity of the twelfth rib to the crest of the ilium, and behind by the vertebral column and the sacrospinalis muscles. The lumbar space varies in size according to the length of the twelfth rib and the type of chest, with its effect upon the position of the ribs. This space is decreased in the slender individual with acutely sloping ribs and increased in individuals with emphysematous chests.

This lumbar region presents several weak points through which a hernia may appear. The most common sites for a hernia are the inferior lumbar triangle of Petit and the superior lumbar triangle or Grynfeldt-Lesshaft space. Until the superior lumbar triangle was described by Grynfeldt, all lumbar hernias were thought to come through Petit's triangle. However, recent investigators believe that most of the hernias appear primarily in the superior lumbar triangle.

The inferior lumbar triangle (Petit's triangle) is fairly constant in its location, bounded in front by the posterior border of the external oblique muscle, behind by the anterior border of the latissimus dorsi, and inferiorly by the crest of the ilium. The floor of the triangle is covered with heavy lumbar fascia beneath which is the internal oblique muscle and deeper still the aponeurosis of the transversus abdominis. The triangle appears with growth and is found more frequently in adults than in children. It is usually not present in well muscled individuals, because the latissimus dorsi is overlapped by the external oblique muscle. The dimensions of the triangle are variable: it may be merely a slit in the aponeurosis or larger with a base measuring 5 to 6 cm. and varying from 1 to 7 cm. in height.

The superior lumbar triangle (Grynfeldt-Lesshaft space) is larger and more constant than the inferior triangle. It is usually present in triangular or tetragonal form, with the triangular type predominating. The size and shape of the space are dependent upon the development of the serratus posterior inferior; the attachment of the external oblique to the last rib; the length of the twelfth rib; the space between the internal oblique and lateral

border of the sacrospinalis; the attachment of the latissimus dorsi to the eleventh and twelfth ribs; the development of the quadratus lumborum and internal oblique muscles. The weakest spot of the superior lumbar triangle occurs where the twelfth intercostal nerve, accompanied by its artery and vein, penetrate the upper part of the space a little below the twelfth rib, where the aponeurosis of the transversus abdominis is not covered by the external oblique.

The superior lumbar triangle is bounded above by the twelfth rib and the lower border of the serratus posterior inferior; in front by the posterior border of the internal oblique muscle; and behind by the anterior border of the sacrospinalis. The floor of the triangle is fascial, being the site of the fusing of the lumbodorsal fascia, which anteriorly forms the aponeurosis of the transversus abdominis and posteriorly splits into three layers to enclose the sacrospinalis and quadratus lumborum. This triangle is above and in front of Petit's triangle.

The formation of a hernia in the lumbar triangles is influenced somewhat by the courses followed by the lumbar and deep iliac circumflex arteries which serve as a path for a potential hernia.

In addition to the superior and inferior lumbar triangles, slits in the aponeurosis caused by trauma or improper development may give passage to small hernias. Although some investigators have postulated the occurrence of a hernia along the cutaneous branches of the second and third pairs of posterior lumbar nerves, this has been refuted by Macready, who pointed out that the nerves run between the muscles and do not penetrate the whole thickness of the parietes at any one point.

Etiology

Two types of lumbar hernia occur, the congenital and the acquired.

Congenital lumbar hernia is very rare. Watson reports only 18 cases in his review of the literature. A congenital hernia is one that is due to malformation or to arrested or deficient development of muscles, aponeuroses, ilium, vertebrae, or lower ribs. These hernias are frequently associated with other developmental abnormalities and may be bilateral.

Acquired lumbar hernias may be either traumatic or spontaneous. These hernias usually occur in adults and are associated with direct or indirect trauma. Spontaneous hernias usually appear in middle or old age, although they may occur at any time after birth. It is generally believed that these cases are due to a congenital predisposition supplemented by indirect injury. Other causes mentioned are obesity, old age, emaciation, chronic bronchitis, emphysema, and occupational straining. A hernia may follow poliomyelitis where certain groups of muscles are weakened. Traumatic hernia usually follows some severe crushing injury, as illustrated in the case reported in this paper, or it may be postoperative.

Symptoms and Diagnosis

Most lumbar hernias are reducible and are relatively easy to diagnose. The mass is usually hemispherical or ovoid in shape and is soft, reducing easily with a gurgling sound. The size and contour of the mass will vary according to the position maintained by the patient. An impulse from coughing may be detected, and, depending upon the contents of the mass, a resonant or a tympanitic percussion note may be heard.

There are usually no very marked subjective or functional symptoms. Occasionally the patient complains of reflex gastrointestinal disturbances with a dragging sensation of weight which disappears when the hernia is reduced.

Strangulation by constriction in lumbar hernia is extremely rare because of the large size of the ring and neck of the sac. In Watson's report of the 115 lumbar hernias, strangulation occurred in only 13, or 11.3 per cent. Spontaneous lumbar hernia is frequently the variety that strangulates, and the most frequent cause of strangulation is a constriction of the neck or a volvulus.

Lumbar hernia may be confused with other conditions occurring in the lumbar region. It must be differentiated from these conditions:

1. *Abscess.* Because of the natural weakness of the lumbar triangles, the lumbar region is a common site for the occurrence of a pointing abscess. Usually these abscesses are soft, fluctuant, and not easily reducible. They are almost invariably associated with Pott's disease.
2. *Lipoma.* Diagnosis is usually simple. The tumor grows very slowly and can be lifted from the surrounding muscles. There are no subjective symptoms.
3. *Fibroma.* This tumor is not so freely movable as the lipoma, since it involves the muscle tissue, but there are no symptoms of hernia. Fibromas are usually of a rather firm consistency.
4. *Muscle Hernia.* This will not reduce and no hernial orifice can be felt.
5. *Hematoma.* There is usually a history of trauma with eventual discoloration of the skin.
6. *Sarcoma of the Ilium.* This very rare condition can be easily identified by its consistency and continuity with bone.

In all of these conditions the symptoms of intestinal obstruction or strangulation are absent, and there is no impulse on coughing or ring on reduction.

Prognosis

Lumbar hernia usually has a favorable prognosis. Strangulation is more infrequent than in other varieties. When strangulation does occur, the hernia can frequently be reduced by taxis because of the large opening and frequent absence of a sac.

Treatment

Mechanical. Lumbar hernias are almost always reducible and occasionally they may be controlled by the use of trusses. As a general rule, however, these

methods are ineffective, because the hernia has a tendency to grow larger.

Injection. The injection treatment of lumbar hernia is now obsolete, and it is almost never attempted. Not only is this treatment useless but it may be very dangerous.

Surgical. In any case of lumbar hernia in which there is no contraindication to surgery, an operation should always be performed. This is the most valuable form of treatment and the only way to insure good results.

The incision for the repair of a lumbar hernia is usually made over the center of the tumor, beginning just below the twelfth rib and extending downward to the iliac crest.

It must be remembered that there is frequently no sac and dissection should proceed cautiously. The sac is never adherent to the skin, and it is usually covered by fat or rarely by muscle. When the hernia consists of only subperitoneal fat, the pedicle is ligated and the tumor excised. The opening is closed with interrupted or mattress sutures of chromic catgut.

In most cases that come to operation the hernia is large. A small lumbar hernia is not troublesome, and patients put off seeking medical aid until the tumor is large. In a large lumbar hernia it is frequently difficult to bring together the muscular and fascial layers. It is possible in some cases to detach a portion of the latissimus dorsi or external oblique muscle and utilize it to close the hiatus.

In 1907 Dowd introduced another method of closure in which he turned a flap made of fascia lata and the aponeurosis up over the gluteus maximus and medius. This flap was sutured in the lumbar fascia, the external oblique, and the latissimus dorsi muscles. The hiatus at the upper part of the wound was narrowed by approximation of the external oblique and latissimus dorsi muscles. A reinforcement was then made by carrying a flap from the latissimus dorsi muscle and suturing it to the aponeurosis of the external oblique muscle.

Another method of closure, introduced by Rishmiller, closed the opening with a flap made by splitting the aponeurosis of the latissimus dorsi muscle. The crest of the ilium was roughened to favor soft tissue attachment. The internal oblique was sutured to the inner split half of the aponeurosis of the latissimus dorsi by chromic catgut. A flap made from the outer split half of the aponeurosis of the latissimus dorsi was turned over the unenclosed arched area just above the ilium and sutured. The superficial fascia was overlapped double-breasted fashion.

In strangulated hernia, operation should be done immediately and the hernia well exposed. The same general rules which apply to any hernia which has strangulated should be followed.

Case Report

A 35 year old white female entered Mercy Hospital on Dec. 16, 1947, complaining of pain in her left side. She stated that on the night of Sept. 24, 1947, she had been run over by an automobile.

The physician called to the accident found that the wheel of the car had passed diagonally across her body from right to left. She had multiple small

Fig. 1—Postero-anterior and left lateral roentgenograms of the abdomen showing the barium-filled colon with a loop of its mid-descending portion extending to the left and posteriorly into the lumbar hernia.

lacerations and extensive bruises over her trunk, but no other injury was discovered at this time.

The patient apparently recovered rapidly and was enjoying good health until a short time before her admission to the hospital, when she began to have sharp pain in her left side. Localized in the left lumbar region and intermittent in character, the pain bothered her most when she lay on her left side.

Physical findings were normal except for a slight bulging on the patient's left side in the lumbar area just above the crest of the ilium. The mass was small, and the bulging could easily be mistaken for fat. On palpation, however, the mass was found to be fairly soft, and there was an impulse readily felt when the patient coughed. The tumor was easily reducible and a gurgling sound could be heard by auscultation.

A barium enema was administered and the radiologist reported that "the colon filled to the cecum, and regurgitation into the terminal ileum occurred. In the left lumbar region there is a hernia with a loop of the mid-descending colon extending into it. Otherwise there is no evidence of organic disease. Conclusion: lumbar hernia containing descending colon."

On Dec. 17, 1947, surgical repair was done. The preoperative diagnosis was traumatic lumbar hernia. Under gas anesthesia with the patient lying on her right side with her left side up, a vertical incision was made toward the back about two inches from the iliac spine. A weakness was found in the region of Petit's triangle. The fascia and adhesions were dissected away and the patient was irritated into coughing so that the bulging could be better visualized. The preperitoneal fat was dissected away from the peritoneal surface. Sutures were taken in the transverse fascia including the peritoneal surface. The preperitoneal fat was then brought over and the deep fascia of the internal oblique and the dorsal lumbar muscles were sutured together with interrupted wire. A part of the fascia which was dissected away from the original site of dissection was then brought over this line of deep fascial sutures to strengthen this region. The muscles and superficial fascia were also sutured to the crest of the ilium to close the triangle of Petit. The skin was closed with clips and no drainage was instituted. The patient left the operating room in good condition and made a satisfactory postoperative recovery.

The patient was last seen on Feb. 10, 1948. At that time she stated she was feeling well and there was no evidence of any weakness in the area of the old hernia.

Comment

This case illustrates a lumbar hernia caused by trauma in an adult. The left side seems to be the most frequent site for lumbar hernia. The absence of a true sac is not unusual, and there is little difference in the sexes affected. A lumbar hernia usually presents little difficulty in diagnosis, and its chief interest lies in its rarity.

(V. W. K.) 19 South Main Street.

REFERENCES

1. Bull, W. T.: See Coley, W. B.: Probable lumbar hernia, Ann. Surg. 22:272–273, 1895.
2. Dowd, C. N.: Congenital lumbar hernia, at the triangle of Petit, Ann. Surg. 45: 245–248, 1907.
3. Goodman, E. H., and Speese, J.: Lumbar hernia, Ann. Surg. 63:548–560, 1916.
4. Higham, A. R. C.: Gangrenous appendix removed from lumbar hernia, Lancet 1: 612 (March 16) 1935.
5. Hume, G. H.: Case of strangulated lumbar hernia, Brit. M. J. 2:73, 1889.
6. Macready, J. F. W.: Treatise on Ruptures. London, Griffin & Co., 1893.
7. Owen, E.: Lumbar hernia; radical operation; recovery. Brit. M. J. 1:957–958 (May 5) 1888.
8. Turner, W. Y.: Lumbar hernia, Brit. M. J. 2:389, 1917.
9. Watson, L. F.: Hernia, ed. 2, St. Louis, C. V. Mosby Co., 1938, pp. 422–434.
10. Iason, A. H.,: Hernia, Philadelphia, The Blakiston Company, 1941, pp. 884–894.
11. Turner, Phillip: Lumbar hernia, Proc. Roy. Soc. Med. 26:50 (Nov.) 1932.
12. Ravdin, I. S.: Lumbar Hernia Through Grynfeldt and Lesshaft's Triangle. Surg. Clinics of No. Am. 3:267–274, 1923.
13. Pizzagalli, L.: A case of lumbar hernia, Boll. d. spec. Med–chir. 2:38, 1928.
14. Yazelle, F.: Hernia lumbar; diagnostico diferencial con lipoma del flanco, Prensa Med. Argent. 31: 2065-2067 (Oct. 11) 1944.
15. Pallasse, E., and Lambert, M.: Hernie lombaire, Lyon med. 142:160 (Aug. 5) 1928.
16. Chianello, C.: On a case of Grynfeldt's strangulated lumbar hernia, Cultura Med. Mod. Palermo 14:496 (Dec. 31) 1935.
17. Ghouilla–Houri, E. V.: Contribution to Study of Lumbar Hernia. Thesis. Paris 1927.
18. Edwards, H.: A case of lumbar hernia, Brit. J. Surg. 14:672 (c) (April) 1927.

ROCKY MOUNTAIN CANCER CONFERENCE TO BE HELD JULY 8 AND 9

The seventh annual Rocky Mountain Cancer Conference will be held in Denver on July 8 and 9. As in previous years there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their ladies. There is no registration fee for this Conference.

Further information may be obtained by addressing Mr. H. T. Sethman, executive secretary, Colorado State Medical Society, 835 Republic Building, Denver, Colorado.

Gamma Globulin and Poliomyelitis

A Statement of Policy and Procedures of Distribution Agreed Upon by the Wisconsin State Board of Health and the Committee on Blood Banks of the State Medical Society

THIS summer limited quantities of gamma globulin, prepared from large pools of human plasma collected by the American Red Cross, will be made available to the various state health departments. These state health departments will then distribute the gamma globulin free of charge to the physicians within their respective states for use in poliomyelitis prophylaxis. This type of gamma globulin is similar in antibody content and is as effective against all three known strains of the poliomyelitis virus as was the gamma globulin which was used as a passive immunizing agent in the extensive controlled field trials during the summer of 1952. It will not be available through private sources.

The agency responsible for the distribution of gamma globulin to the various states is the Office of Defense Mobilization. Plans for the allocation of the globulin are at present in the process of final formulation by the National Research Council Panel on Allocation for Gamma Globulin, and preliminary plans have been submitted to the Office of Defense Mobilization.

The state health departments within each of these states will be responsible for the distribution of gamma globulin to their physicians. In such distribution it is expected that the state health departments will comply with the specifications of the Office of Defense Mobilization and will adhere to its recommendations. It is not expected that the present specifications will be changed materially when finally adopted.

The Wisconsin State Board of Health and the State Medical Society would like to make the following information available to the physicians of the state at this time.

Expected Basic Allocation of Gamma Globulin to Be Made to Wisconsin for Poliomyelitis Prophylaxis. The Wisconsin State Board of Health will receive from the Office of Defense Mobilization a basic allocation of 33,960 cc. of gamma globulin for poliomyelitis prophylaxis during 1953.

This quantity is based on a national distribution formula of 40 cc. times the average yearly number of cases reported during the five year period 1947 to 1951. The average number of cases reported in Wisconsin during this period was 849.

It is likely that additional quantities of gamma globulin will be made available to the State Board of Health from time to time whenever the number of reported paralytic cases exceeds the cumulative mean for any given period or for areas of unusual epidemic incidence. However, the possibility of receiving such additional supplies cannot be made the basis for present distribution planning.

Adequacy of the Basic Allocation. There seems to be little doubt that the supply of gamma globulin is inadequate on the national level. It is important that some estimate of the adequacy, or inadequacy, of the basic allocation to the State of Wisconsin be determined in relation to its possible needs. However, such estimation is likely to be highly inaccurate in view of fluctuation in epidemic incidence from year to year, and from area to area.

The following considerations should be of some significance. The average of 849 cases for 1947 to 1951 upon which the basic supply of the state is determined is approximately two-fifths of the 2,213 cases which were reported in 1952. It is unlikely that the number of cases which will be reported in 1953 will be less than the total reported for last year. There has been a constant progressive rise, almost tenfold, from the 206 cases reported in 1947 to the number reported last year.

The method of dosage determination must also be considered in estimating the adequacy of the supply. The recommended quantity of gamma globulin for use in poliomyelitis prophylaxis is 0.14 cc. per pound of body weight. Thus, five children in the 0 to 4 year age group could be immunized for each adult who could be so immunized. In 70 per cent of the cases reported in Wisconsin, the patients were 15 years of age and under. It is obvious that a far greater number of contacts could be immunized in this age group than in the older age group. Moreover, almost 50 per cent of all household contacts to poliomyelitis cases are 15 years of age and under.

Restrictions in Gamma Globulin Distribution for Use by Physicians. Because of the obviously limited supply the distribution of gamma globulin to physicians will be restricted for use in individuals in the following groups of contacts to clinically diagnosed cases:

1. *Household contacts 15 years of age and under.* This refers to those individuals who have not reached their sixteenth birthday, and are regular residents of a household in which an acute case of poliomyelitis has been clinically diagnosed.
2. *Pregnant household contacts, regardless of age.*

Other Specifications of the Office of Defense Mobilization. In order to meet the specifications of the Office of Defense Mobilization for the distribution of gamma globulin to physicians, special request forms have been devised. These will be distributed to physicians when supplies of gamma globulin become available to the State Board of Health for poliomyelitis prophylaxis. The following information will be required before a request can be filled:

1. Name, address, and age of patient.
2. Date of onset of illness.
3. Date of diagnosis.
4. A provisional determination whether the case is paralytic or non-paralytic.
5. The names, ages, and weights of all household contacts 15 years of age and under.
6. The name and term of gestation of any pregnant member of the household.
7. The name and address of the physician making the request.

Where to Make Your Request. In order to expedite the distribution of gamma globulin to physicians for use in household contacts, gamma globulin for poliomyelitis prophylaxis will be distributed normally only through the following two channels:

1. City health departments with full-time medical health officers.
2. District offices of the Wisconsin State Board of Health.

Physicians residing in cities belonging in the first category should send their requests to their respective health departments. These cities are Milwaukee, Madison, Racine, Kenosha, Janesville, Sheboygan, and West Allis.

Physicians who do not reside in the above cities should send requests to their respective *district offices of the State Board of Health.*

At the time that request forms are distributed, physicians will receive additional information from their city health departments if they reside in the cities listed above, or from their proper district offices. The State Board of Health at Madison will supply gamma globulin for poliomyelitis prophylaxis directly to physicians when unusual circumstances prevent distribution through the usual channels. It will continue to distribute gamma globulin for measles and infectious hepatitis prophylaxis directly to physicians on receipt of completed request forms for these diseases. These forms are already in the physicians' possession and should not be confused with the request forms for gamma globulin for poliomyelitis which will be distributed in the near future.

The Reporting of Poliomyelitis Cases. Inasmuch as the Wisconsin statutes require the reporting of disease to local health officers, physicians are reminded that requests for gamma globulin to the State Board of Health, either directly to the Bureau of Communicable Diseases or to the district offices, do not constitute an official case report. They are urged to continue reporting cases to their local health officers as usual.

Since additional supplies of gamma globulin, over and above the basic allocations, may be distributed by the Office of Defense Mobilization and will be determined by the number of cases reported above the average for a given period or in a given area, failure of a physician to report all cases to local health officers (whether or not gamma globulin is required for household contacts) may result in a failure to secure sorely needed supplementary allocations to the state.

Case Follow-Up. It has been recommended by the Office of Defense Mobilization that follow-up studies of the efficacy of globulin immunization in household contacts should be instituted in the states. For years, the Wisconsin State Board of Health, with the cooperation of the physicians of the state, has secured epidemiologic follow-up investigation on all reported cases.

Points to Remember. The State Medical Society of Wisconsin has approved the general plan for distribution of gamma globulin by the State Board of Health and the necessary restrictions and recommendations of the Office of Defense Mobilization. It is the desire of both organizations to effect the most rapid and equitable distribution of such supplies as are allocated to Wisconsin as long as they are available. To effect this, not only the cooperation, but the understanding of the problem by the practicing physician is essential. It would be well to keep the following points in mind:

1. **For prompt distribution, requests should be made to the appropriate office. The State Board of Health or your City Health Department will notify each physician individually and inform him exactly where to direct his requests.**
2. **For prompt and adequate distribution all information sought on the request forms must be obtained. Should you find it necessary to make your request by phone or in person please have all the necessary information at hand.**
3. **A request for gamma globulin does not constitute a legal case report. It is particularly important that *all* your cases be reported to your local health officers as usual, especially when you make requests to the district offices of the State Board of Health or to the State Board of Health in Madison. *Report your cases even when there are no eligible contacts for immunization.* Failure to comply with this paragraph may result in a decrease in necessary supplementary allocations of gamma globulin to Wisconsin by the Office of Defense Mobilization.**
4. **Continue your cooperation, as in past years, with the State Board of Health in its subsequent epidemiologic follow-up of cases and contacts.**
5. **Assist the State Board of Health, the State Medical Society, and voluntary agencies in their efforts to secure public understanding, allay public hysteria, and avoid unnecessary immunization. Explain to your patients the limited supply of gamma globulin, the need for carefully controlled and restricted use, and the temporary nature of passive immunization. The value of such public understanding, both to the practicing physicians and the distributing agencies, is obvious.**

Addison's Disease with Protracted Unusual Mental Changes

By VALERIUS V. QUANDT, M. D. and SAMUEL ROSENTHAL, M. D.
Hartford Milwaukee

Historical

IT WAS in 1855 that the English clinician, Thomas Addison, presented a description of the syndrome which came to bear the name Addison's disease. Addison uncovered the disease of the adrenal glands while investigating the mechanism and causation of what is now known as pernicious or Addisonian anemia.[1]

His attention to patients who were subsequently discovered to have involvement of the adrenal glands resulted from the fact that they presented the symtoms of marked weakness and circulatory deficiency similar to those seen in patients with pernicious anemia.

Signs and Symptoms

The signs and symptoms of Addison's disease in order of importance are the following:[2]

1. *Weakness and Easy Fatigability.* These complaints are so commonplace that they cannot be used to make a diagnosis of Addison's disease, yet the diagnosis should never be made unless these complaints are outstanding features of the patient's story. One important aspect of the weakness of Addison's disease is that it is constant during the day and does not vary from day to day. In functional fatigue, on the other hand, the tiredness usually decreases as the afternoon wears on or evening appears. This change in energy in functional fatigue is probably due to the distraction brought on by the day's activities.

2. *Abnormal Pigmentation or Depigmentation.* The skin slowly assumes a bronze or sun-tanned appearance. This pigmentation is particularly evident over areas of contact such as the elbows, the knees, and the waist. Pigmentation of brownish black color can often be seen on the mucous membranes of the gums and the inner aspect of the cheek.

3. *Weight Loss.* Weight loss is a constant finding. If the patient was obese before the onset of the disease, the loss of weight may not be evident.

4. *Hypotension and Small Heart Size.* The systolic blood pressure is usually below 100 mm. The pulse pressure is also reduced. In rare cases a patient with pre-existent hypertension may have a normal blood pressure at the onset of the disease. Furthermore, unless there has been previous rheumatic heart disease or hyperthyroidism, the heart size on x-ray examination is below the anticipated normal. Another feature of the x-ray of the chest is the decrease in the vascular markings of the lung.

5. *Loss of Appetite, Nausea, Vomiting, and Diarrhea.* Gastrointestinal symtoms are very common. Many patients with Addison's disease are treated and operated on for "chronic appendicitis," "chronic cholecystitis," and "peptic ulcer" before the underlying disease is recognized. One differential characteristic between peptic ulcer and Addison's disease is that in peptic ulcer hyperchlorhydria is usually present, while in Addison's disease hypochlorhydria is a usual symtom.

6. *Hypoglycemic Manifestations.* An abnormally low blood sugar, especially after gastroenteritis, which may prevent the ingestion of food, is common in Addison's disease. Many patients with Addison's disease have learned by experience that if a meal is deferred, spells of sweating, tremor, and nervous irritability develop which are relieved by the ingestion of carbohydrates.

7. *Dizziness and Fainting Attacks.* These episodes of dizziness and syncopal attacks may occur after any effort or illness or as the result of delaying the ingestion of food. They are partly due to hypoglycemia as well as to hypotension.

8. *Nervous and Mental Symptoms.* Nervous and mental symptoms may develop so insidiously that the patient is not aware of them. The mental changes may vary from irritability to delirium or frank psychoses. In recent years the mental changes which accompany Addison's disease have been recognized. Evidence of changes in the personality of the patient should always be sought by asking the patient's relatives.

Laboratory Aids in Diagnosis

Because the complaints of weakness and easy fatigability, as well as the symptoms of weight loss and dizziness, are so universal and commonplace, the laboratory must be used to help in the diagnosis of Addison's disease. Since alterations in the blood chemistry are found only in the advanced forms of the disease, tests of adrenal function must be employed. Two of the more important and safer tests are the following:

1. *The Robinson–Power–Kepler Test:*[3, 4] This procedure is based on two facts in the pathologic physiology of adrenal cortical deficiency.

(a) After the rapid intake of a considerable quantity of water, patients with Addison's disease do not experience normal diuresis but continue to excrete a fairly concentrated urine.

(b) Patients with Addison's disease tend to excrete large amounts of sodium chloride in the urine but to retain urea.

The procedure is carried out as follows. On the day before the test the patient eats the usual meals but omits extra salt. No food or water is taken after 6:00 p.m. At 10:00 p.m. he is requested to empty his bladder and discard the urine. All urine voided from then until 7:30 a.m. is collected. The volume of this urine is measured and the specimen saved for chemical analysis if this becomes necessary. Breakfast is omitted. The patient is asked to void again at 8:30 a.m., and immediately thereafter he is given 20 cc. of water per kilogram of body weight (9 cc. per pound). He is asked to drink this within the next 45 minutes. At 9:30, 10:30, and 11:30 a.m. and 12:30 p.m. he is requested to empty his bladder. During the entire test the patient is kept at bed rest except when he gets up to void.

If the volume of any one of the hourly specimens voided during the morning is greater than the volume of urine voided during the night, the test is negative and indicates that the patient does not have Addison's disease. If the volume of the largest hourly specimen voided during the morning is less than the volume of night urine, the response is positive, and Addison's disease may or may not be present. In this event the following additional procedures should be undertaken.

A blood specimen is drawn while the patient is still fasting, and the plasma is analyzed for its content of urea and chloride. The night urine is analyzed for its content of urea and chloride. From these data the following equation is solved:

$$A = \frac{\text{Urea in urine}}{\text{Urea in plasma}} \times \frac{\text{Chloride in plasma}}{\text{Chloride in urine}} \times \frac{\text{Vol. of day urine}}{\text{Vol. of night urine}}$$

The volume of day urine refers to the largest of the hourly specimens: the volume of night urine is the entire amount which was voided from 10:30 p.m. to 7:30 a.m. The values may be expressed in any units, as long as the same system is used throughout. It seems least complex to express the chloride and urea estimations in milligrams per hundred cubic centimeters and the urine volumes in cubic centimeters.

If the value of A is greater than 30, the patient probably does not have Addison's disease. If the value is less than 25, the patient probably does have Addison's disease. Severe disturbances of fluid metabolism, such as those which occur in nephritis, diabetes insipidus, and dehydration states must be excluded before attempting to interpret the results of this test.

2. *The ACTH test as reported by Thorn, Forsham, Prunty, and Hills in 1948:*[5] In this test an eosinophil count is made, and then 25 mg. of adrenocorticotrophic hormone is injected intramuscularly. Four hours thereafter another eosinophil count is made. Addison's disease is excluded with a fall of 50 per cent or more in circulating eosinophils.

Case Presentation

A. L., a 41 year old white female, came to our attention in January 1950, at which time she was involved in an auto accident, which caused a 3 inch scalp laceration but no apparent systemic effects. Her scalp wound was repaired and she returned to her home for rest. The patient, however, remained weak, tired, and apathetic. She said later that just before she was injured she had planned to seek medical advice because of progressive lassitude for about six months. She was hospitalized on Feb. 1, 1950, where blood studies showed a hemoconcentration and a blood sugar of 61.7 mg. per hundred cubic centimeters. By this time she had become very depressed, weak, anorexic, and loath to talk or to be handled. Her blood pressure, when it could be obtained, was 75/30 mm. of mercury. At times it was almost imperceptible. She was given parenteral fluids, including saline solution and 3 cc. of adrenal cortical extract daily, with gradually decreasing dosage. Subjective and objective improvement was noted within 24 hours. She was continued on 1 cc. daily injections of adrenal cortical extract, with additional sodium chloride, 2 Gm. three times daily. Her improvement in general strength and feeling of well-being continued and she was discharged from the hospital 14 days after her admission. Her blood pressure rose to 110/70 mm. of mercury and her weight increased from 95 to 104 pounds. Soon she was able to continue her occupation as a secretary.

On May 13, 1950, we implanted a 75 mg. pellet of desoxycorticosterone acetate intragluteally and the administration of adrenal cortex was discontinued. After three months this therapy was reinforced with parenteral adrenal cortical extract. Another 75 mg. pellet of desoxycorticosterone acetate was implanted on Oct. 14, 1950, and a third pellet on March 5, 1951. In similar fashion she used adrenal cortical extract after she noted the effect of the pellet wearing off and before a fourth pellet was used on Sept. 1, 1951. Though the patient did not feel strong, she was able to work steadily at her employment.

On Oct. 21, 1951, the patient was found in bed in a comatose condition. Her mother stated that she had noted nothing unusual except the presence of a light cold the previous day. She was removed to the hospital and during the ensuing 72 hours she remained in deep coma. Prominent physical findings were those of fibrillary muscular twitchings and convulsive movements. There was considerable facial grimacing, and choreiform serpentine movements of her limbs. She received water and electrolytes intravenously, together with large doses of adrenal cortical extract. Doses as high as 100 cc. daily were used. After a week she was able to feed herself. She remained dull, however, and was frequently incoherent during the remainder of her 31 day period of hospitalization.

She was then given 25 mg. of oral cortisone twice daily, which was soon decreased to 25 mg. daily. Within a week she noted greater improvement with return of vigor and appetite. Her blood pressure ranged from a systolic of 110 to 120 mm. of mercury, and a diastolic of 74 to 80 mm. of mercury. She gained weight to 110 pounds. She returned to her

work and was in better condition than at any previous time since the diagnosis was first made. She does not recall any of the events that occurred during her month's stay in the hospital. Subsequent and recent blood studies on this patient show the following results:

Serum potassium 20.2 mg.% (Normal 20 mg.% plus or minus 2 mg.%)
Serum sodium 350 mg.% (Normal 310–334 mg.%)
Serum chloride 500 mg.% (Normal 450–500 mg.%)

At the same time the Robinson-Power-Kepler test was given. Results showed that the night passage of urine was 225 cc., and two of the hourly specimens taken during the day exceeded this volume. These data, coupled with the clinical observations, would indicate a favorable response to therapy. A recent electroencephalogram was reported as normal.

Pathologic Physiology

The known functions of the adrenal cortex include the excretion of sodium, potassium, chloride, and water. In addition it has functions in regulating the blood sugar level and the metabolism of melanin. In the absence of adequate amounts of adrenal cortical hormone there is an excessive renal loss of sodium and chloride and a renal retention of potassium, with a resultant dehydration and a hemoconcentration. There is also a decreased ability of the kidneys to excrete water, which forms the basis of the Robinson-Power-Kepler test. As a result of the hemoconcentration and reduced plasma volume, blood pressure is lowered and cardiac size decreased. The exact manner by which the adrenal cortical hormone regulates the excretion of these electrolytes appears to be unknown. Similarly, the manner in which the adrenal cortex regulates melanin metabolism is not clear.

Discussion

It is interesting to note that as early as 1940, Grattan and Jensen[6] observed as a result of experiments on mice that those adrenal cortical principles containing an oxygen atom at C_{11} exert a significant influence on carbohydrate metabolism. These 11-oxysteroids are as follows:

11—dehydrocorticosterone (Compound A)
corticosterone (Compound B)
11—dehydro–17–hydroxycorticosterone (Compound E or cortisone)
17—hydroxycorticosterone (Compound F)

Cortisone is a name introduced by Dr. E. C. Kendall of the Mayo Foundation to identify a compound which had previously been referred to as 17–hydroxy–11–dehydrocorticosterone or as "Kendall's Compound E."[7] It has been pointed out that cortisone is about one-fiftieth as effective as desoxycorticosterone acetate in causing retention of sodium.[8] It is also evident that cortisone can restore normal water diuresis to patients with adrenocortical insufficiency. It is possible that by regulating the distribution of water between cells and extracellular fluids, cortisone renders water available for excretion after water loading.[9] The administration of cortisone has definite effect on carbohydrate metabolism, as indicated by a diminished hypoglycemic response to insulin and a better maintenance of the blood sugar level during prolonged fasting. In contrast, desoxycorticosterone acetate has weak power in adjusting the blood sugar level.[10] Grattan and Jensen[11] found that cortisone and other 11-oxysteroids raised the resistance of fasting mice to convulsive doses of insulin and caused an increased deposition of glycogen in the liver. These findings are further borne out by Levy,[12] who has reported on 6 cases of Addison's disease. These patients had originally received desoxycorticosterone acetate, with inadequate control of the blood sugar level and with episodes of crisis due to hypoglycemia. After the initiation of oral cortisone therapy their condition improved. They gained weight and exhibited a more normal glucose tolerance curve. Desoxycorticosterone acetate was used concurrently with cortisone in these cases. Salassa[13] at the Mayo Clinic has reported the case of a patient with Addison's disease complicated by diabetes mellitus who was given cortisone and desoxycorticosterone acetate. In this patient the insulin requirement increased from 12 to 58 units a day, a level approximately the same as that which was required before the development of adrenal insufficiency. Thorn[14] reported on patients with classical Addison's disease at the Peter Bent Brigham Hospital who received Compound E alone or in combination with desoxycorticosterone acetate. He found that his patients had an increased sense of well-being, in some instances bordering on euphoria. Coincidentally he found marked improvement in the electroencephalographic tracing, reflecting the action of the hormone on the metabolism of the central nervous tissue. When cortisone was used jointly with desoxycorticosterone acetate in daily doses of 5 mg. or larger, the serum sodium level actually decreased further, indicating some manner of blocking effect between the two drugs at these doses. Knowlton[15] states that the treatment of Addison's disease can more closely approximate the therapeutic goal when it is learned what steroids are secreted normally and in what amounts. He stresses that the therapeutic requirements will vary from patient to patient. Among the 33 patients under observation at the Columbia–Presbyterian Medical Center, 2 were maintained on sodium chloride alone. It has been Knowlton's experience that desoxycorticosterone acetate is useful in maintaining electrolyte balance where sodium chloride alone is inadequate. He has also found that cortisone is definitely useful in a number of patients with Addison's disease who continue in poor health even after adequate control of the electrolyte balance. He finds that the effect of cortisone in producing a satisfactory electrolyte balance varies in different patients. He concludes that the response of the patient should be the determining factor in selecting the drugs for therapy.

Summary

We have listed the symptoms, physical signs, and several of the laboratory aids in the diagnosis of Addison's disease. Recent reports on drugs in current use are reviewed. Specific therapeutic requirements in each patient must be individualized. We presented the history of a patient with classical Addison's disease which was well controlled with 25 mg. of cortisone orally each day. The patient's experience shows that in spite of severe mental changes, including coma, treatment of Addison's disease can be successful.

(V. V. Q.) 55 North Main Street.

REFERENCES

1. Thorn, G. W., and Forsham, P. H.: Adrenal Cortical Insufficiency, in Williams, R. H.: Textbook of Endocrinology, Philadelphia, W. B. Saunders Company, 1950, p. 249.
2. Thorn, G. W., Forsham, P. H., and Emerson, K., Jr.: The Diagnosis and Treatment of Adrenal Insufficiency. Springfield, Illinois, Charles C. Thomas, 1949.
3. Robinson, F. J., Power, M. H., and Kepler, E. J.: Two new procedures to assist in the recognition and exclusion of Addison's disease, Preliminary Report, Proc. Staff Meet., Mayo Clin. 16:577–583 (Sept. 10) 1941.
4. Wells, B. B.: Clinical Pathology, Application and Interpretation, Philadelphia, W. B. Saunders Company, 1950.
5. Thorn, G. W., and others: A test for adrenal cortical insufficiency, J.A.M.A. 137:1005–1009 (July 17) 1948.
6. Grattan, J. F., and Jensen, H.: Effect of the pituitary adrenocorticotrophic hormone and of various adrenal cortical principles on insulin hypoglycemia and liver glycogen, J. Biol. Chem. 135:511–517 (Sept.) 1940.
7. Ingle, D. J.: The biologic properties of cortisone: Review, J. Clin. Endocrinol. 10:1312–1354 (Oct.) 1950.
8. Thorn, G. W., and others: Advances in the diagnosis and treatment of adrenal insufficiency, Am. J. Med. 10:595–611 (May) 1951.
9. Oleesky, S., and Stanbury, S. W.: Effect of oral cortisone on water diuresis in Addison's disease and hypopituitarism, Lancet 2:664–666 (Oct. 13) 1951.
10. Cluxton, H. E.: Carbohydrate studies in patients with Addison's disease treated with testosterone propionate and cortisone, J.M.A. Georgia 39:408–416 (Oct.) 1950.
11. Grattan, J. F., and Jensen, H.: Effect of pituitary adrenocorticotrophic hormone and of various adrenal cortical principles on insulin hypoglycemia and liver glycogen, J. Biol. Chem. 135:511–517 (Sept.) 1940.
12. Levy, M.S.: Oral use of cortisone in chronic adrenal cortical insufficiency, J.A.M.A. 149:411–415 (May 31) 1952.
13. Salassa, R.M.: Effects of cortisone and ACTH in certain endocrine conditions, Proc. Staff Meet., Mayo Clin. 25:497–498 (Aug. 16) 1950.
14. Thorn, G. W., and others: Clinical and metabolic changes in Addison's disease following the administration of Compound E acetate, Tr. A. Am. Physicians 62:233–244, 1949.
15. Knowlton, A. I.: The modern treatment of Addison's disease, Med. Clin. N. America, (New York Number) 36:721–737 (May) 1952.

ANNUAL CONVENTION OF THE INTERNATIONAL ACADEMY OF PROCTOLOGY

All physicians are cordially invited to attend the fifth annual convention of the International Academy of Proctology to be held at the Plaza Hotel, New York City, May 29, 30, and 31, 1953, immediately preceding the American Medical Association Meeting. This year the meeting will be extended to include a surgical clinic and seminar at Jersey City Medical Center under the direction of Dr. Earl J. Halligan. The "wet clinic" and seminar will be on May 28. An extensive motion picture seminar of proctologic surgery (including office technics) will be held on May 31. All scientific papers will present the latest developments in proctology and gastroenterology.

Because general practitioners as well as gastroenterologists and proctologists face proctologic problems in their daily practice, much of the program has been planned to answer their questions.

There is no fee for attendance at the annual convention of the International Academy of Proctology. These conventions, as well as all other activities of the Academy, are directed toward the further development of proctology. All physicians interested in proctology are therefore invited and welcomed to the annual meeting.

The program will be available in the near future, upon request to the Executive Offices of the International Academy of Proctology, 43–55 Kissena Blvd., Flushing, New York.

Degenerative Disease of the Hip Joint*

By CHARLES M. IHLE, M. D.
Eau Claire

IN THIS discussion about degenerative disease of the hip joint, I am going to try to answer three questions. The first, What is degenerative disease of the hip joint? The second, How can I tell when the patient has the disease? The third, What should I do for him when I find out that he has it?

Degenerative disease of the hip joint is simply the breaking down or the wearing out of the joint. The symptoms are pain, limitation of motion, and deformity. That triad of symptoms has been known through the ages. The disease has acquired a variety of names. We know it in the aged as *malum coxae senilis;* in the young, as *malum coxae juvenilis.* The clinician, the pathologist, and the roentgenologist, looking at it from different viewpoints, use different terminology, such as degenerative, hypertrophic, or osteoarthritis. The English know it as *arthritis deformans.* It is sometimes called *traumatic arthritis.* The name *chondromalacic arthrosis* has been suggested, while the layman simply says "rheumatism."

We do not know the etiology of degenerative disease of the joints, but we do know about the factors that contribute to the degenerative process. We know, for instance, that joints do break down and that the process can be accelerated by numerous factors. Among these are faulty structure of the joint, such as a shallow acetabulum that allows subluxation; gross injuries, such as fracture and slipped epiphysis; diseases, such as Perthes' disease, aseptic necrosis, rickets, gout, and infection; and the microtraumata of faulty posture and excessive weight bearing. We know that senescence is accompanied by degeneration of the tissues and a loss of their resiliency, so that ordinarily the older the joint, the greater the deterioration. We know, too, that different joints in different people of the same age may show different stages of degeneration. We also know that there may be degeneration in one patient in middle age and not in another of the same age. We know that in a patient of a given age there may be degeneration of one hip joint and not of the other. We know these things, but we do not know why they occur. We are not going to give any theory. For our purpose, it will suffice to say that degenerative disease of the hip joint is a breaking down or wearing out of the joint and that the daily wear and tear, the uses and abuses, the stresses and strains, to which the joint is subjected, the diseases that attack it, the injuries that befall it, and even the stuff of which the joint itself is made all contribute to the degenerative process.

The symptoms are pain, limitation of motion, and deformity. The x-ray changes at first, or early in the breaking-down process, may show only a narrowing of the joint space, representing a thinning of the articular cartilage, or cystic changes in the acetabulum and femoral head. Later, the joint space may be entirely obliterated, with bone rubbing against bone instead of cartilage padding against cartilage. Nature, in its attempt to repair, may have built up growths of bone called spurs and osteophytes. Still later there may be such marked change in the joint that the surfaces become incongruous. No longer is the head round, fitting nicely into its socket, but ovoid and rough, and the acetabulum has adapted itself to these irregular contours.

Since in the patient with minimal x-ray change the symptoms somewhat parallel the x-ray changes—that is, a narrowing of the joint space, but no osteophyte formation—we would expect pain, and perhaps limitation of motion because of muscle spasm, but no actual deformity. In the patient with x-ray changes that show bony overgrowth about the base of the femoral head and the rim of the acetabulum, indicating osteophyte formation, we again would expect pain. We would certainly expect limitation of motion, and there might even be deformity. In the individual with the x-ray picture of an incongruous joint, again pain would be present and there would be not only limitation of motion but deformity as well.

Ordinarily the patient would tell us about his pain. The limitation of motion and deformity we would have to determine for ourselves by examining the hip; by flexing it and extending it, by turning it inward and outward, by moving it toward and away from the midline, and comparing its motions either with a good hip or with motions we know to be normal in the type of individual that we are examining.

The earliest and most usual change in motion is in rotation, especially inward rotation. Then follows limitation of motion in extension and abduction.

Now, when we examine the hip, the patient should be on his back on the examining table. To check for rotation, we flex the thigh somewhat, flex the knee so that the leg can be used as a lever, and then rotate the hip inward and outward. To determine whether the patient has a flexion contracture, we flex the opposite hip until the thigh lies against the abdomen and the normal lumbar curve is obliterated, so that the patient's back lies flat on the examining table. If a flexion contracture is present, the thigh on the side of the contracture will be raised from the table. The amount that it is raised will give us the degree of contracture, or flexion deformity. There is always the tendency for the limb to be rolled outward at the hip, to be drawn toward the

* Presented before the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952.

midline, and to be pulled up somewhat in flexion. We might expect, then, that an individual with degenerative disease of the hip joint would walk with his foot directed lateral to the line of progression, because of his external rotation at the hip, and to limp as though he had a short leg, because of his flexion deformity and attitude of adduction. An individual who complains of pain and has limitation of motion or a deformity in the hip, and has x-ray changes, might readily be identified as one who has degenerative disease of the hip. The individual, however, who complains of pain but has no x-ray changes, as is likely in the early stages of the disease, presents a greater diagnostic problem.

To make the diagnosis of degenerative disease of the hip joint, we must, of course, rule out other affections. We must know that the patient does not have a fracture or a sprain. We must be sure that his pain is not originating in his back. Pain either in the buttock or in the posterior aspect of the hip joint that runs down the course of the sciatic nerve and into the leg below the knee is not the pain of degenerative disease of the hip joint. Pain that is in the anterior aspect of the hip joint and in the groin, and runs down the medial and anterior aspect of the thigh to the front of the knee, however, *is* the pain of hip joint degeneration. Pain on weight bearing and movement of the hip joint, night pain, pain that is relieved by rest and inactivity, pain that is present on arising and then eases up with activity and later reappears with fatigue—that is the pain of hip joint degeneration.

Now, what should we do for the patient? Each patient is a therapeutic problem in himself. The type of treatment depends on the patient's age, his occupation, what he expects to be able to do with his hip, what he must be able to do with his hip, and whether he is willing to sacrifice motion to be rid of his pain or needs to increase the motion in a stiffening joint and is willing to experience some pain to regain that lost motion. It depends, to a great extent, on the degree of change in the hip joint, as shown on the x-rays, and whether or not the patient is willing to submit to surgery, if it is indicated. Then, finally, it depends on whether the patient is relieved of his symptoms by the treatment that is inaugurated.

Generally, we divide the treatment into conservative and operative measures. Conservative measures should be tried first. They are rest, exercise, heat, and salicylates.

There are different ways to rest the hip. A plaster cast will rest and immobilize the joint, while recumbency in bed will rest the joint and allow some non-weight-bearing motion. Crutches or a cane provide rest and partial weight bearing. Then there is the partial rest from weight bearing obtained by simply decreasing the amount of activity, such as stair climbing, standing, and walking. Traction will often relieve the acute attack of pain that is caused by muscle spasm, the pain that awakens the patient at night with sudden, jerking movements of the hip.

By exercises are meant non-weight-bearing exercises, both active and passive. Active exercise is the movement of the joint instituted by the patient himself, using his own muscles, while passive exercise is movement of the joint by another person. The patient who moves his hips about, moves the thigh up and down and rolls his lower extremity in and out while sitting or lying will find it much easier to get going when he tries to bear his weight again.

Heat can be obtained in many ways: by wearing warm clothing, such as long underwear or a long coat; by changing to a warm climate; by using hot packs or liniment, an electric pad, or a heat lamp, and by massage.

Salicylates should be taken in the form of ordinary aspirin, or, if the patient has difficulty taking aspirin, in the form of bufferin, enteric-coated aspirin, or anacin. Taken before meals and at bedtime with a cold glass of water on a regular schedule, aspirin is more helpful than salicylates taken haphazardly on a full stomach and with only a sip or two of water.

Do this for your patient: outline a regimen for him. Have him limit his weight-bearing activities by riding and sitting whenever he can. When he is sitting, have him move his hip joints often. Help him set aside regular rest periods during the day, have him try to eliminate stair climbing, advise him to use a crutch or cane, recommend that he re-arrange his work area so as to cut down on the number of steps, admonish him to wear warm clothing, tell him about the other forms of heat, and put him on a regular course of salicylates. Those who fail to obtain enough relief to carry on their necessary activities may be candidates for one of the surgical procedures.

The operative measures may attack either the joint itself or the nerves to the joint. Individuals whose pain is anterior may obtain marked relief with obturator neurectomy. Because it is a relatively simple procedure, and not a long and disabling one, it is worth trying on those whose demands on the hip joint are not great. Surgical procedures that attack the joint itself are those procedures that stiffen the hip and remove all motion, and those that are directed toward improving motion through reconstruction of the hip, at times substituting prostheses for the components of the joint. An arthrodesis will relieve the patient completely of pain and will destroy all motion in the joint. It is the procedure of choice in the individual who demands a rugged weight-bearing extremity, such as the farmer. It is for the individual who is willing and able to sacrifice all motion to get rid of his pain. It is not the surgery for the aged. It is not the surgery for the young person who has minimal changes in his hip joint. It is not the surgery for the individual who is willing to accept some pain in order to keep motion in his hip joint. The individual who needs or wishes to have motion may derive enough benefit from an arthroplasty to be able to carry on his activities. Arthroplasty, together with those meas-

ures used in conservative treatment, may alleviate the symptoms in some individuals. In an individual who has bilateral hip joint disease an arthrodesis may be necessary on one side for a standing hip, while an arthroplasty may be required on the opposite side for the moving or going hip in order to allow the patient to return to work. Sometimes, in a patient with bilateral hip joint disease, an arthrodesis on the worst side may sufficiently relieve the other hip of weight bearing to enable the patient to get about, work, and be comfortable. Any surgical procedure undertaken must be such that it does not close the door to further surgical procedures. For example, an individual may have an arthroplasty during his earlier years and need an arthrodesis later. The surgery for the arthroplasty, then, must not destroy the components of the joint so that an arthrodesis cannot later be performed. Thus, each patient must be analyzed; his needs, his actual joint changes, and his temperament must be weighed, and a treatment chosen as a balance.

In many instances Compound F, or Hydrocortisone, injected directly into a painful joint gives dramatic relief from pain for periods lasting from 2 to 10 or more weeks. In others, it fails completely to relieve the patient. It is a very promising drug, but whether the patient whose pain has been eliminated by using it will abuse the joint, as is done in a neuropathic joint, and further hasten its breakdown is a question that will be answered only as time and statistics inform us.

---

314 East Grand Avenue.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES POSTGRADUATE COURSE

A postgraduate course in pediatrics will be offered by the University of Wisconsin under the direction of Dr. John E. Gonce, Jr., professor of pediatrics, on May 19, 20, and 21. Though primarily a lecture course, pediatric clinics and periods for question and answer sessions will also be included. The use of faculty members from many departments of the University of Wisconsin Medical School assures the course of the broadest possible base.

TUESDAY, MAY 19

A.M.

8:30 Registration
9:00 Use of ACTH and Cortisone in Pediatric Practice—Dr. H. A. Waisman
10:00 Diagnosis and Treatment of Meningitis—Dr. K. B. McDonough
11:00 Infant Feeding—Doctor Gonce

P.M.

1:30 Common Endocrine Disturbances among Infants and Children—Dr. E. S. Gordon
2:30 Problems in Diagnosis and Treatment of Poliomyelitis—Dr. H. D. Baernstein
3:30 Pediatric Nursing Problems — Miss Margaret C. Crump
4:30 Pediatric Clinic—Staff

WEDNESDAY, MAY 20

A.M.

8:00 The Problem of Serious and Fatal Reactions to Drugs—Dr. J. E. Steinhaus
9:00 Comments on Pediatric Surgery—Dr. E. R. Schmidt
10:00 Electrolyte and Fluid Balance — Doctor Waisman
11:00 Treatment of Emotional Disturbances in Children—Dr. E. S. Cameron

WEDNESDAY, MAY 20

P.M.

1:30 Dermatologic Disorders in Infancy and Childhood—Dr. S. A. M. Johnson
2:30 Diagnosis and Treatment of Convulsive Disorders in Infancy and Childhood—Doctor McDonough
3:30 Interpretation of Roentgenograms of the Chests of Children—Doctor Gonce
4:30 Pediatric Clinic—Staff

THURSDAY, MAY 21

A.M.

8:00 Subdural Hematoma—Dr. T. C. Erickson
9:00 Congenital Heart Disease—Dr. G. M. Maxwell
10:00 Use of Antibiotics and Untoward Reactions to Antibiotics—Dr. J. K. Curtis
11:00 Pediatric Anesthesia Problems—Dr. O. S. Orth

P.M.

1:30 Common Orthopedic Problems in Infants and Children—Dr. H. W. Wirka
2:30 Visual Disorders in Children with Special Reference to Reading Difficulties—Dr. P. A. Duehr
3:30 Erythroblastosis—Dr. H. K. Tenney, III

The course is limited to 45 persons, and advance registration will be necessary for attendance. The fee is $10. Address inquiries to R. C. Parkin, M. D., University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

The Dietary Management of the Pregnant Patient*

By ALLAN C. BARNES, M. D.**
Columbus, Ohio

THE importance of this topic is obvious but it needs frequent re-emphasis. The pregnant patient knows that nine months later, plus or minus a little, she will go through a traumatic surgical procedure with a blood loss that is measured not in ounces but in hundreds of cubic centimeters. If we can send her into that surgical episode in good condition, the chances of morbidity or mortality will be much lower. At the same time we have the unparalleled opportunity of feeding two people as we are feeding one, and of preparing the baby for the trauma of being born. As prenatal care is the most important part of the obstetrician's armamentarium, so the prenatal diet is the most important part of our prenatal care.

A number of fallacies have grown up around the prenatal diet, and these fallacies need to be set aside with each patient individually. The first of these fallacies is: "You are eating for two." To the extent that the fetus must get its nutritional elements from the mother, either from what she already has or what she ingests during the pregnancy, this is true, but it is not true in the caloric sense. The pregnant woman does not need to double her food intake. It is even possible for the mother to lose weight during her pregnancy and still give her fetus the elements that it will need to grow and survive.

"Drink plenty of milk." This expresses one of the casual wave-of-the-hand attitudes about the dietary instructions. It does not encompass what the patient needs to be told. Nutrition is a science. We know what it takes to build a newborn baby. We know what the placenta will transfer and the circumstances under which it carries materials to the baby. We know what must be available and we cannot pass all of this knowledge off with a casual, "Drink plenty of milk." The advice must be given systematically and individually.

The pregnant woman should go on the delivery table at her *ideal* weight plus about 20 pounds. This sum constitutes her "date-of-expected-confinement weight." It is not her *average* weight plus 20 pounds. It is her *ideal* weight as calculated from the height-weight charts plus 20 pounds. Twenty pounds more or less represents the baby, the amniotic fluid, the placenta, the increase in weight of the uterus, and the weight added under the influence of the patient's high steroid level. This last increment amounts to 7 per cent of the pre-pregnancy weight. These 20 pounds will disappear. Those pounds over and above that amount will remain with the mother.

At the time of the initial physical examination, the patient's ideal weight is calculated and she is told how many pounds she can gain, or how many she must lose in order for her to go to the delivery room table at her ideal weight plus 20 pounds. Fortunate is the woman who will be permitted to gain all 20 pounds. Some are restricted to as little as 5 pounds and some must lose weight to reach the end of their pregnancy at this figure. After arriving at the correct figure for that individual patient, we can list the dietary ingredients she is to eat to help her achieve that objective and at the same time to build a new citizen.

Few things lead to more disrespect for the diet and more disregard for the doctor than the mimeographed sheet that is pulled out of the bottom left-hand drawer and given to the patient. Any woman with intelligence to choose her obstetrician carefully has the intelligence to see that such a sheet was not made out with her in mind. Her intention of following it is diminished accordingly. Even a few scratch-marks made here and there to raise or decrease the amount of milk she drinks still do not make it her individual diet sheet. The doctor who writes out a prescription for Unicaps (which the patient could buy by just saying the word to the pharmacist) may not be willing to take time to write out an individual prescription for her diet. The diet sheet should be hers and hers individually, and is worth the extra five minutes it takes to write it. Since she knows it was written after the doctor examined her and knew something about her, she will be more likely to do something about it.

What shall be written on this slip of paper? At the moment let us omit any detailed discussion of calories and mineral elements and confine ourselves to the practical business of writing a diet for the individual woman who is our patient at the moment.

"One quart of milk." Actually this goal is not always achieved. For some curious reason milk cannot be consumed by a considerable percentage of adult women. If the patient will drink three glasses a day, the battle is won. Two glasses a day should be the minimum. Milk is needed for its proteins as well as for its calories, and calcium pills cannot replace all of these. A calcium supplement is just that—a supplement. It is meant to complement a good food intake, not replace it.

Next on the list is "an egg a day." For the nursing mother this would be two but for the pregnant mother one will do. The egg furnishes principally proteins and mineral elements.

---

*Presented before the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952.

**Professor of Obstetrics and Gynecology, Ohio State University College of Medicine.

The third big source of proteins is "meat: two servings per day." The baby is made overwhelmingly of flesh over a calcium skeleton. The three items we have listed, milk, eggs and meat, eaten in adequate amounts for six months, will give the baby sound flesh and a firm calcium skeleton. The patient may use meat substitutes such as beans, cheeses, and eggs. Be sure she does not have the mistaken idea held by a number of women that spaghetti and macaroni are meat substitutes.

She should eat "three vegetables per day," at least one of them green and leafy in type. These are the principal source of vitamins. We do not need to supplement the diet with vitamins. In a properly constructed diet, the vitamins will be supplied by the foods and do not need to be taken in capsule form.

"Two servings of fruit" are recommended. At least one of them should be fresh. Both may be.

"Three or four servings of whole wheat." Whole wheat may be in the form of whole wheat bread, Wheaties, shredded wheat, biscuits, Wheatena, or any of the dark grain cereals. "Cracked" wheat is at least 50 per cent whole wheat and can be recommended if the patient will not take other types. White cereals—white bread and Cream of Wheat—do not count even if they are marked "enriched." Enriched bread is bread from which all the vitamins and mineral elements have been removed and part of the vitamin B has been put back. But we are not concerned about the vitamin B content of the wheat foods. It is the minerals they provide that makes them important. Incidentally, though, they are the best source of vitamin E.

Expectant mothers need "two pats of butter" or oleo. I feel a little hesitant about putting oleo on the chart in a dairy state. The food value of the two is, however, almost identical.

Now, this diet feeds the patient as far as she herself is concerned. But it does not get in all she needs for the second patient, the baby. We know, for example, that she is shy on iron. She cannot get enough iron in her food to make an entire new blood stream. So iron must be added as a supplement. Other elements that need to be added vary with geography and with the patient's eating habits. Calcium needs to be added for the patient who cannot take adequate amounts of milk. Vitamins may be needed for the patient who is not preparing her food properly or who does not get the proper quality.

Iron should be given in the ferrous form as the sulfate or as the gluconate. Small doses are sufficient. Three grains twice a day is enough. A good share of that will pass on out in the stools. She will probably absorb as much from 3 grains twice a day as she will from 5 grains three times a day. Larger doses may constipate the patient.

If the patient on this diet drinks her full quart of milk she will get about 1.8 Gm. of calcium. That is sufficient. There is every reason to suspect that a calcium supplement lowers the available calcium somewhat, curious as that may sound, and does not do a great deal of good. Certainly a half gram of calcium given twice or three times a day is ridiculous. Since the patient cannot absorb that much, the hard-baked, chalky stool of excessive calcium is added to the black, hard stool of iron, and we have created an entirely new problem for ourselves.

We are discussing supplements, not substitutes. These are not to take the place of the diet. The pregnant patient cannot live entirely on pills. She must eat the foodstuffs, not substitutes. The supplements can be added where necessary. The addition of vitamins would probably be unnecessary except for the fact that vitamin B is water soluble and many of our able cooks boil it out of our vegetables and pour it down the drain. Vitamin B also is destroyed by alkalies. The trick of making string beans look greener by boiling them in sodium bicarbonate will effectively remove the vitamin B. Faulty preparation of food can destroy its vitamin content.

I object to giving the patient three prescriptions, one for iron, one for calcium, and one for vitamins. My objection is that pregnancy is a physiologic phenomenon for a patient of this age, not a disease of nine months' duration. This patient is doing what she should be doing, and if we send her home with a handful of prescriptions and she sits down at the table every day with a row of bottles in front of her, she ends up with the idea she must be very sick indeed to have to take all these medications. We can combine them. Almost every drug house makes a supplemental capsule that is reasonably satisfactory. One supplemental capsule or two, not six, will usually bring the mineral and vitamin content up to a satisfactory level.

The need for thyroid perhaps depends on geography. It becomes the patient's principal source of iodine. Every thyroid tablet has some iodine in it. The most common cause of spontaneous abortion in our part of the country is a mild degree of thyroid deficiency. The problem of congenital goiter has not disappeared from all areas. No child has been born with congenital goiter from a mother who took thyroid extract during her pregnancy. The patient has a physiologic drop in her metabolic rate during pregnancy. A grain a day of thyroid, taken every morning before breakfast on an empty stomach, maintains her at her nonpregnant level and avoids much of that fatigue of the third, fourth, or fifth months of pregnancy. It keeps her feeling closer to normal.

Everything we have said so far is a positive admonition. These things must be done. This must be eaten. There is one negative admonition: "You must add no salt at the table." We are so used to thinking of desoxycorticosterone as the steroid which retains sodium, the hormone that is used for Addison's disease, that we forget the obvious truth that all steroid hormones—testosterone, progesterone, the estrogens—are salt retainers. The patient is going to have a much larger number of steroid hormones in her body during the coming months than she had in the nonpregnant state. The toxemias of pregnancy can be largely avoided by reducing the amount of sodium.

Let us think a little about the amount of sodium chloride this patient needs. No meat-eating animal needs to eat salt. The animal that goes to the salt block is a vegetarian: the horse, the cow, and the antelope. I never saw a block of salt put out in a zoo for the lion to lick. You never saw your dog stop and lick up a pile of salt. *The meat-eating animal does not need salt.* Man is partly vegetarian and partly meat eating, but the average American makes up for that by preparing the vegetarian portion of his food with sodium chloride. By the time the average American diet is set on the table, it contains three times the daily requirement of sodium chloride. Added salt at the table is unnecessary, and predisposes to edema and toxemia. We must remind the patient that table salt is not her only source of sodium. Sodium bicarbonate, "Tums," "Bisodol," and many other remedies she may be inclined to use contain sodium. Since she is on a high-protein diet, she cannot possibly be on a sodium chloride-deficient diet. If she maintains the protein intake we specified, she can safely restrict herself at the table.

All together the daily diet list looks like this:

Milk: one quart
Egg: one
Meat: two servings
Vegetables: one green leafy, two others
Fruit: two servings, one fresh
Whole wheat: three servings
Butter: two pats
Supplements: thyroid and iron, vitamins and calcium, if necessary

This is the patient's individual list. Since it is a minimum list, we tell her she may add desserts, soups, coffee, tea, and other foods.

What are we going to do for the patient who must lose a few pounds? First, we modify the diet by lowering its fat content. The amount of milk is reduced to two glasses and we make it skim milk. It should be dairy-skimmed rather than kitchen-skimmed milk. We still keep the eggs, but have them poached or boiled, not fried or scrambled. Fried foods pick grease out of the frying pan and raise the fat content of the diet.

Two servings of *lean* meat. Here goes the pork chop, here goes the ham with its fat on the side. The meat should be lean and must be boiled, broiled, or roasted. "No gravy" should be written, for there is no sense in telling your patient to broil meat to eliminate the fat and then eat the fat in gravy.

Vegetables may stay as they are, but the patient is allowed only one fruit per day. This must be eaten fresh in order to preserve the vitamin C content. The bread is limited to two or three servings per day, the butter reduced to one pat per day. The vitamin supplements are retained, and the need for salt restriction is especially emphasized with the overweight patient.

It is necessary to instruct the patient about the size of the servings, since there is considerable difference of opinion about this. A serving of peas, for example, is a heaping tablespoon, and a serving of beef is a thin slice, not a plateful. By limiting the size of the servings we can bring the diet down to about 1,800 calories without harm to mother or baby. If the patient will remain active, she can reduce her weight on this number of calories.

For the toxemic patient further modification must be made. The best method of control is dietary. Sodium must be completely eliminated. She must have sweet butter and salt-free bread. Cabbage and other high sodium foods are to be avoided. Make sure she takes no sodium bicarbonate or other preparations that contain sodium. Increase the protein. The toxemic patient loses protein in her urine and needs additional amounts in her diet. The administration of parenteral salt-free protein to these patients is one of the best ways of promoting diuresis. Ammonium chloride in adequate dosage, at least 6 Gm. per day, will be tolerated by most patients and will also help release water from the tissues.

Doctors preach constantly the value of preventive medicine. The American Medical Association conducts widespread campaigns urging the people to ask for preventive examinations. There are only two places where the American public has purchased preventive medicine on a large scale. One is for the child in the first year of life; mothers will take the well baby to a pediatrician. The other example of consistent preventive medicine is during pregnancy. Now that puts it up to us. If it does the good we say it does, this is the place we cannot fail to fulfill our responsibility. This is one of the most important obligations we have to meet. The public has said, "All right, you say preventive medicine will do the job. Here I am in your hands, preventively, and not feeling ill. You are assigned the job of keeping me well." The dietary control of the pregnant patient is one of the finest examples of the way that we can practice preventive medicine. It is a challenge the patient is giving us, one that we can ill afford to drop.

Ohio State University College of Medicine.

MARK THESE DATES ON YOUR CALENDAR!

The 1953 Annual Meeting of the State Medical Society will be held on Tuesday, October 6, through Thursday, October 8, at Milwaukee. *If you are a delegate:* Note that the first meeting of the House of Delegates is tentatively set at 10:00 a.m., Monday, October 5. *If you are a golfer:* The golf tournament will be held at North Hills Country Club, Milwaukee, Monday, October 5, during the afternoon. Dinner and awards that evening.

Cardiac Arrest and Resuscitation

Report of Two Cases

(Strabismus Surgery and Repair of Pectus Excavatum)

By E. E. ECKSTAM, M. D.; D. E. MINGS, M. D.; O. S. BLUM, M. D.; G. R. BARRY, M. D.; J. R. WEIR, M. D.; and F. C. STILES, M. D.*

Monroe

THE current literature has an increasing number of articles on cardiac arrest and resuscitation. The following report of our experiences with two patients illustrates what can be done in any well-equipped hospital when such a catastrophe occurs.

Case Reports

CASE 1—D. G., a 5 year old boy, was admitted to the hospital on June 25, 1951, for strabismus surgery on his right eye. He was born prematurely at 7½ months and weighed 3¾ pounds. One month after birth, a Fredet–Ramstedt operation was performed for hypertrophic pyloric stenosis. He contracted nearly all of the childhood diseases. He also had a bilateral, nonparalytic exotropia. An earlier operation on the left eye had been performed without complications on Nov. 7, 1950, but the exotropia was undercorrected.

On June 26, 1951, the patient received premedication rectally with 60 mg. of pentobarbital at 8:00 a.m., and intramuscularly with 0.2 mg. of atropine at 10:00 a.m. Induction with nitrous oxide and oxygen was started at 10:25 a.m.; ether was started at 10:30 a.m. The ether was given intermittently, and the nurse anesthetist noted resistance at each administration. As surgical anesthesia was approached, this resistance decreased. Two drops of 4 per cent cocaine, with a drop of adrenalin chloride 1:1000, were put in the right eye.

The incision in the right eye was made at 10:35 a.m. By about 10:55 a.m. resection of the external rectus muscle had been completed, and the incision for resecting the internal rectus muscle was made. At this time, the anesthetist noted that the patient had considerable mucus in the pharynx. As she attempted to remove the mucus by suction with a metal catheter, the patient became cyanotic, and the operation was suspended. The ether hook was removed, a pharyngeal airway inserted, and oxygen given by artificial respiration with the anesthesia machine. The pulse, blood pressure, and heart tones were absent.

At 11:00 a.m. 1.5 cc. of Coramine was given intramuscularly; 0.2 cc. of adrenalin chloride was given intracordally through the chest wall. When this had no effect, the surgeon operating in the next room was summoned.

At 11:05 a.m. an incision was made in the left anterior fifth intercostal space, without skin preparations. The fifth and sixth costal cartilages were cut to provide more room. First the heart was pressed for several seconds against the mediastinum without effect. Then it was grasped and squeezed about once a second. This procedure considerably improved the color of the patient. At 11:06 a.m., 0.4 cc. of adrenalin chloride was injected into the right ventricle. But the moment the needle struck the myocardium, the heart started to beat at 180 beats per minute, and the adrenalin was injected while the heart was beating. The patient's color immediately returned to normal. Procaine hydrochloride, 1 cc. of a 2 per cent solution, was injected into the pericardial sac to prevent undue irritability of the myocardium. Artificial respiration was continued at about 30 per minute. At 11:10 a.m., the chest was closed in layers with continuous sutures. A number 8 catheter was brought out the medial end of the incision and connected to 15 cc. of water at negative pressure. The lung was fully expanded. The pulse was 180 beats a minute, there were no respirations (30 per minute by artificial respiration), and the blood pressure was 134/0 mm. of mercury.

The rate of respiration was decreased to 12 per minute. Two cubic centimeters of caffeine sodium benzoate was given intramuscularly, and 5 cc. of aqueous adrenal extract and 1 cc. of digiglusin were given intravenously. At 11:35 a.m. an intratracheal tube was inserted, and a small tube was passed into the stomach to deflate it. An electrocardiogram showed a sinus tachycardia.

At noon the first spontaneous respiratory attempt occurred diaphragmatically and continued at 3 per minute. Two cubic centimeters of caffeine sodium benzoate was given intramuscularly, and the soda lime absorber was turned off for about 4 minutes each 15 minutes to stimulate respiration. Another 2 cc. of caffeine sodium benzoate was given intramuscularly and 100 mg. of procaine amide hydrochloride (Pronestyl) was given slowly intravenously to avoid cardiac arrhythmias.

At 12:40 p.m., a bronchoscopic aspiration was performed to remove mucus. The patient coughed once at this time. His rectal temperature was now 101.8 F., blood pressure 130/80, pulse rate 180, respiratory rate 12 (partially assisted). The incision in the eye was closed without completing the corrective procedure. At 1:00 p.m., the patient's respiratory rate was 12 per minute (unassisted) and artificial

* From The Monroe Clinic, Departments of Surgery, Ophthalmology, Medicine, and Pediatrics, assisted by Registered Nurse Anesthetists Sisters M. Laura and M. Edna Marie.

respiration was discontinued. At 1:30 p.m. the intratracheal tube was removed and a pharyngeal airway inserted. Oxygen was continued at 6 liters per minute by catheter.

At 1:45 p.m, the patient was returned to his room, unconscious but breathing regularly at 14 per minute. His color was good, and his pulse and blood pressure remained the same. Blood and fluids were started slowly to increase the blood volume and reduce the pulse rate.

About 3:30 p.m. he began to have fibrillary muscular contractions, almost Jacksonian in type. These were controlled with about 50 drops (1 mg.) of an 0.5 per cent solution of pentothal sodium, given intravenously, every 5 to 10 minutes. At 5:00 p.m., the patient's temperature had risen to 105.5 F., and repeated alcohol sponges, ice packs, and ice enemas were given. At 7:00 p.m. he began to perspire freely, his temperature began to fall, and his muscular contractions ceased. By this time, blood (250 cc.), normal saline (500 cc.), and glucose (5 per cent, 500 cc.) had been given. The pulse slowed to 160, and the blood pressure was the same.

At 8:00 p.m. Cheyne-Stokes respirations began and the lungs filled with mucus. Catheter aspiration of the pharynx and the trachea was done frequently. Aqueous adrenal extract (10 cc.), 20 per cent calcium gluconate (10 cc.), and digiglusin (1 cc.) were given intravenously. At 9:00 p.m. the pulmonary edema had cleared and respirations were normal. The patient's temperature stayed below 104 F. and he appeared to be sleeping normally.

At 11:00 p.m. his blood pressure began to fall, his pulse weakened, and cyanosis appeared. He became cold and clammy. Aqueous adrenal extract (10 cc.) and digiglusin (1/2 cc.) were given intravenously. The last blood pressure reading was 65/55 at 12:20 a.m., pulse rate 150, respiratory rate 12. Each respiration became more shallow. The patient died at 12:35 a.m., June 27, 1951, 13 hours and 40 minutes after cardiac arrest.

Autopsy revealed that all organs were normal except the pylorus, which was slightly thickened and scarred from surgery. The lumen was adequate. The right adrenal gland appeared normal and measured 0.5 by 1.5 by 3.5 cm.; the left adrenal gland was hemorrhagic and indurated and measured 1.0 by 2.0 by 4.5 cm. The thymus was relatively large and weighed 40 Gm. It caused no apparent obstruction. The heart weighed 118 Gm. and was normal. The lungs showed congestion and the postero-inferior portions cut like liver. There was no evidence of pulmonary edema. The brain was removed and showed hyperemic vessels. Coronal sections (after fixation) showed possible petechial hemorrhages in the basal ganglia. The vessels at the base of the brain were normal. No evidence of increased intracranial pressure was present. A small cavity was present in the septum pellucidum.

Microscopically, the liver, spleen, thymus, and kidneys showed congestion. The heart was normal. The lungs showed congestion, edema, and purulent bronchitis. The adrenal gland on the left showed pericapsular hemorrhage and marked cortical congestion with medullary extravasation of blood. The right adrenal gland was normal. The brain showed severe cerebral hyperemia, cerebral edema, and minimal generalized petechial hemorrhages.

Case 2—B. B., a 20 month old boy, weighing about 35 pounds, was admitted to the hospital on Aug. 18, 1952, for correction of a pectus excavatum. When first seen in the Monroe Clinic at the age of 8 months, he was normal in all respects other than a slight depression of the sternum. On re-examination more than a year later, the deformity was considerably increased, and surgical correction was advised.

On Aug. 19, 1952, drop ether was started at 8:35 a.m. At 8:50 a.m., an intratracheal tube was inserted, and the pharynx packed with gauze. A polyethylene tube was placed in the left ankle vein and a slow drip of 5 per cent glucose in water was started.

At 9:10 a.m., a vertical incision was made over the sternum. The pectoralis major muscles were dissected from the costal cartilages and retracted laterally. The rectus muscles and fascia were resected from the costal arch, and the sternum and right costal cartilages were freed from the mediastinum and parietal pleura by finger dissection. A right pneumothorax occurred as these costal cartilages were sectioned from the sternum. The left costal cartilages were also sectioned from the sternum, and an anterior transverse wedge osteotomy was done at the junction of the manubrium and gladiolus. The gladiolus was held at a normal angle with two wire sutures through the anterior cortex.

About this time (9:40 a.m.) the anesthetist reported that there was possible cyanosis and that the fingers and facial muscles had been twitching. During the next half hour there was considerable difficulty in maintaining adequate oxygenation.

Vertical anterior wedges of cartilage were removed from the costochondral junction and the cartilages were each supported in their new position by wire sutures. The pleural defect was closed and the medial ends of the cartilages were trimmed to fit the sternum and held to the sternum with wire sutures. The cartilages were cut a little short to support the sternum better and to reduce paradoxical motion.

As the left costal cartilages were being freed from the mediastinum, the left pleural space was entered. Very shortly, at 10:25 a.m., the heart stopped beating. The pericardium was immediately entered; the heart was grasped in the hand, and squeezed about once a second. In about 2 minutes the ventricles began to fibrillate and 5 cc. of 2 per cent procaine was put into the pericardial sac. Before a defibrillator could be used, the heart began to beat feebly at about 80 beats a minute. By 10:31 a.m., the heart was beating normally. The pericardium was closed and the operation resumed. The stomach was deflated with a tube, and the patient's condition was better than before cardiac arrest.

Shallow anterior wedges of cartilage were removed from the left costochondral junction and no sutures were needed. The medial ends were trimmed and united to the sternum as on the right side.

At 10:50 a.m., when a catheter was passed through the intratracheal tube to aspirate mucus, cardiac arrest again occurred. The left medial wire sutures were removed, the pericardium was reentered, and cardiac massage was instituted as before. Two per cent procaine hydrochloride (10 cc.) was instilled into the pericardial sac to avoid cardiac irritability. The heart beat started very quickly and within five minutes was normal. The pericardium was again closed and the wire sutures replaced. A number 8 catheter was placed in each pleural space by means of a stab wound below each nipple, and 10 cm. of water at negative pressure was applied.

The xiphoid cartilage was removed and the anterior rectus fascia was united to the sternum and costal arch with interrupted (2–0) silk sutures. The pectoralis fascia was reattached to the sternal periosteum with the same suture material. The skin was closed with a continuous silk suture. A satisfactory repair had been obtained. An elastoplast dressing was applied.

The patient was kept in the operating room and was given 100 per cent oxygen. Artificial bag respiration was necessary for the first 20 to 30 minutes after the second cardiac arrest. By 11:45 a.m. the patient was reacting and responding to questions, and he was returned to his room. He was placed in an oxygen tent, and negative pressure was maintained on the chest catheters. He continued to improve and acted normally later in the day except for increased restlessness. He was given penicillin, lipoadrenal extract, phenobarbital, and aspirin. During the first 24 hours, fluids were given on the basis of maintenance therapy plus additional amounts because of the hyperthermia (103 F. rectally). This amounted to 2,155 cc., including 300 cc. of normal saline, 150 cc. of Ringer's solution, and 175 cc. of whole blood. The sodium chloride content was estimated to be 4 Gm., somewhat over the daily normal requirement.

At 9:20 a.m. on the day after surgery, the patient had a small convulsion. All fluid therapy was stopped. He was given 30 mg. of phenobarbital, intramuscularly, and 10 cc. of 20 per cent calcium gluconate intravenously. But the convulsions increased. By 10:00 a.m. he had rales in his chest. In order to control the cerebral and pulmonary edema, he was given 250 mg. of aminophylline intravenously, and 0.2 mg. of atropine sulfate, intramuscularly. A phlebotomy was attempted and 50 cc. of blood was removed. By noon, the convulsions ceased. During the afternoon he had several bouts of emesis. By 7:00 p.m. he was breathing normally and resting fairly well. Urine output was adequate and only oral fluids were given. The next morning he was alert and recognized his parents.

Postoperative chest x-rays revealed that the mediastinum was in the midline and that the lungs were fully expanded. The chest catheters were removed in 48 hours. He gradually improved and was dismissed on Aug. 27, 1952.

He was last seen in the office six weeks after the operation. Examination showed the sternum to be in normal position with little paradoxical motion. The pectoralis muscles were improving in strength, but he still could not brace himself adequately if he fell forward. He acted normally; all his reflexes were normal, and his parents reported that they noted no personality change or mental retardation.

Comment

In case 2, it is felt that the prolonged hypoxia plus brief periods of anoxia caused a minimal amount of cerebral damage. However, there must have been enough cerebral damage to cause the cerebral edema that occurred after the administration of fluids and saline in amounts which ordinarily would do no harm. It would have been better to have given no saline. We were fortunate in having both a good operative result and a normal patient.

Summary

Two cases of cardiac arrest and resuscitation are reported. In the first one, which occurred during strabismus surgery, cardiac massage was instituted too late to permit the patient to recover. The second case occurred during the repair of a pectus excavatum. Recovery was complete because cardiac massage was begun immediately. The basic factor of hypoxia is present in both. A discussion of cardiac arrest with these two cases as examples is presented in this issue in the article prepared by the Wisconsin Anesthesia Study Commission.

WISCONSIN HEART ASSOCIATION ANNUAL MEETING

Saturday, May 23, is the date of the annual meeting of the Wisconsin Heart Association in Milwaukee. Scientific sessions will take place in the auditorium of the Marquette University School of Medicine, and the evening meeting will be held at the Wisconsin Club. Feature at the evening meeting will be a talk on the history of the knowledge of heart disease by Dr. Harold Feil, a professor of medicine at Western Reserve University and head of the cardiology divisions at the Lakeside hospitals in Cleveland. Doctor Feil will also present a scientific paper and will take part in a panel on pathology.

A Change In State Laboratory Services

As It Looks to Your State Board of Health

WITH the beginning of the state's new fiscal year on July 1, 1953, the State Laboratory of Hygiene in Madison will handle bacteriologic specimens and water samples which have heretofore been sent to the various city laboratories designated as state cooperative laboratories.

These laboratories, located in the cities of Beloit, Green Bay, Kenosha, La Crosse, Oshkosh, Sheboygan, Superior, and Wausau, have played an important part in the control of communicable diseases during the 35 years since their establishment. But with the changing demands made for their services and with increasing administrative problems, it has become more practical to release them from performing services for the state so that they can function solely for the municipalities in which they are located.

For example, demand for the analyses of water samples alone has increased far in excess of the ability of the cooperative laboratories to meet it, and most of these samples have been coming from outside the jurisdiction of the cities. The rapidly increasing work load in the field of milk sanitation has also added to the administrative problems, because the cities co-sponsoring the laboratories want more and more of the services of the bacteriologist.

Most of the milk and cream examinations and the swab tests to determine the sanitary conditions of dishes in public eating establishments are primarily for the protection of residents of the city in which the laboratory is located. Each of the cities will now decide for itself whether to continue to operate the laboratory to do such tests and any other laboratory procedures peculiar to their own localities.

After the State Board of Health has withdrawn from the cooperative laboratories on July 1, certain specimens for bacteriologic examination will be sent to the State Laboratory of Hygiene in Madison. This will relieve the demands made upon those local laboratories and give them time to devote to the special needs of the cities themselves. This arrangement is the consummation of plans that were made years ago; namely, that these laboratories would eventually become local laboratories as the cities became aware of their importance.

With the opening of the new State Laboratory of Hygiene building in Madison early this year, facilities have been provided to take over the examination of those specimens and samples which can no longer be handled by the cooperative laboratories. This has been made possible because the new building of the State Laboratory of Hygiene is adequate to accommodate a larger staff. Another factor in the change is that railroad facilities, air facilities, and bus service have made Madison more accessible. The transportation of specimens is not the serious problem it often was in the early years.

In addition to these duties, the State Laboratory of Hygiene will be enlarging its services in several other fields where laboratory examinations are essential in a case-finding program for disease.

Diseases must be located before it is possible to investigate their occurrence. This is illustrated in the case of certain virus diseases. It is known, for example, that ornithosis exists in this state. The incidence of the disease is not known, however, since accurate diagnosis (case-finding) depends upon definitive tests which are carried out in laboratories with the personnel available and trained for such technical procedures.

For this reason it is not known how widespread this disease is among fowl, pigeons, wild birds, or pheasants. The failure of definitive diagnosis in this field is illustrated by the diagnosis of atypical pneumonia. This may spring from a variety of etiologic agents, but the definitive cause in this group of diseases has yet to be determined.

The new Laboratory of Hygiene will be carrying on tests in this field and in other fields having a similiar purpose.—W. D. STOVALL, M.D., *Director, Division of Laboratories.*

FIRST WORLD CONGRESS ON FERTILITY AND STERILITY

The First World Congress on Fertility and Sterility, sponsored by the International Fertility Association in conjunction with the American Society for the Study of Sterility, will be held at the Henry Hudson Hotel in New York City from May 25 to 31, the week before the annual meeting of the American Medical Association. The program will include 22 scientific sections dealing with practically every phase of fertility and sterility. Authorities in the field have been invited from 48 nations.

The registration fee of $20.00 for non-members or $5.00 for members of either society should be sent to the Chairman, Arrangements Committee, World Congress on Fertility and Sterility, 1160 Fifth Avenue, New York 29, New York.

THE MEDICAL FORUM

FEDERAL SECURITY AGENCY GETS DEPARTMENTAL STATUS

THE PRESIDENT OF THE UNITED STATES, Dwight D. Eisenhower, poses for his picture with leaders of American medicine just before he addressed a special session of the American Medical Association's House of Delegates at the Hotel Statler, Washington, D. C., on March 14. Standing, left to right, are Mrs. Oveta Culp Hobby, Secretary of the new department; President Eisenhower; Dr. E. Vincent Askey, Los Angeles, Vice-Speaker of the AMA House of Delegates; Dr. E. J. McCormick, Toledo, President-Elect of the American Medical Association; Dr. Dwight H. Murray, Napa, Calif., Chairman of the Board, AMA; Dr. Elmer L. Henderson, Louisville, Past President of the AMA and Chairman of the Association's Liaison Committee with the Federal Security Agency; and Dr. Louis H. Bauer, Hempstead, N. Y., AMA President.

Mrs. Hobby to Have M.D. as Special Assistant

Washington, March 26.—With passage of the Presidential Reorganization Plan No. 1 through the House of Representatives and the Senate, the elevation of the Federal Security Agency to departmental status is assured. The reorganization raises former FSA Administrator Oveta Culp Hobby to full cabinet rank.

As Secretary of Health, Education and Welfare, Mrs. Hobby will be in charge of the United States Public Health Service, Office of Education, Social Security Administration, Office of Vocational Rehabilitation and the Food and Drug Administration. She is to have a special assistant in charge of all health and medical affairs who is to be a doctor of medicine with wide, non-governmental experience.

This special assistant is to be a presidential appointee, subject to confirmation by the Senate. He will be the top staff policy adviser to Mrs. Hobby with respect to health and medical matters. He will have responsibility for reviewing the health and medical programs throughout the agency and recommending improvements where necessary. He will represent Mrs. Hobby on top level inter-departmental committees and serve as liaison with important non-governmental groups, such as the AMA. He will also represent the Secretary at various international meetings such as the World Health Assembly of the World Health Organization. He will coordinate related health and medical programs within the department.

Other top level assistants to Mrs. Hobby will be an under-secretary and two assistant secretaries, all to be appointed by President Eisenhower.

The House of Delegates of the AMA met in special session in Washington March 14 to consider the new plan as presented to them by the President himself. The plan received the delegates' approval,

(Continued on page 240)

PHYSICIANS FORUM PUBLIC RELATIONS SUCCESS FOR FLORIDA MEDICAL GROUP

St. Petersburg, Fla., March 24.—Once a week for 12 weeks each year, members of the Pinellas County, Florida, Medical Society stand before a large audience and hand out wholesale amounts of medical advice, free.

They are the physicians who are participating in the Medical Forum, sponsored by the society and the St. Petersburg Times. One of the doctors delivers a short lecture on the topic for that night—a topic selected in advance by Times readers. Other members of a panel take turns answering questions, also submitted in advance.

This unique attraction, which plays regularly to packed houses, has drawn nation-wide attention. The Times is in the process of distributing five thousand copies of a brochure describing the mechanics of setting up a forum.

Eight physicians appear on the forum each time—one giving the lecture and the others answering the questions. As many as 45 questions are answered in one evening. The participating doctors make a practice of leaving ahead of the audience and not remaining to answer additional questions after the program.

To supplement this year's series a tape recording is being made of each forum which is broadcast Sunday evenings. Recordings are also made available to clubs and civic groups.

SENATOR ROBERT TAFT addresses the AMA House of Delegates.

FED. SECURITY AGENCY . . .

(Continued from page 239)

but they reserved the right "to make recommendations for amendment of the then existing law and to continue to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control."

The reorganization is expected to relieve the situation in which Mrs. Hobby found herself when she assumed her post. As nominal director of 37,500 federal employees, she discovered it was not possible to place her own people in key positions. There were only three jobs open for her own appointees, all carrying the title of Assistant to the Administrator. She has filled one of these posts and abolished another.

All other FSA positions, with the exception of three held by presidential appointees, are covered by civil service, which protects job incumbents to varying extents. The change in status will doubtless mean the opening of a number of departmental positions.

Mrs. Hobby expressed herself as being favorable to the suggestion that the AMA appoint a committee to which she could turn for assistance and cooperation. The committee, which was accordingly appointed, includes Drs. E. L. Henderson, chairman; Louis H. Bauer, vice chairman; Edward J. McCormick, Dwight H. Murray and F. J. L. Blasingame. Dr. Walter B. Martin was named as an alternate member.

Representatives Davis (R), Zablocki (D), Kersten (R), Van Pelt (R), Laird (R) and Byrnes (R) voted in favor of the reorganization plan. Representatives Smith (R), Withrow (R) and O'Konski (R) voted against it. Hull (R) did not vote.

MacCornack Eager to See Wisconsin Assume Prominent Place in Rural Health Matters

Madison, March 25. — Medical care facilities in rural areas are increasing rapidly through cooperative, voluntary efforts of medical, farm and community groups, according to Dr. R. L. MacCornack, Whitehall.

Dr. MacCornack, the member of the State Medical Society Council on Medical Service who is responsible for rural health activities, attended the eighth annual National Conference on Rural Health at Roanoke, Va. February 27–28.

The meeting drew more than 600 representatives of medical, agricultural, university extension services and other groups with a combined membership of several millions. Forty-two states and the District of Columbia were represented. The conference is sponsored by the Council on Rural Health of the AMA.

According to Dr. MacCornack, the subject of selling young physicians on the idea of practicing in rural areas was particularly stressed. "A physician who has spent 8 to 13 years of his life in being trained to practice modern medicine is not willing to settle in an area where there are no facilities for practicing it," said Dr. MacCornack. A number of instances were cited where doctors were obtained through community effort to build a clinic or hospital and provide living quarters at a reasonable rental.

Fine summaries on the subject of voluntary group health and accident insurance coverage were given by Dr. Carll S. Mundy, Toledo and Frank W. Peck, Chicago, managing director of the Farm Foundation.

DR. R. L. MacCORNACK

According to Dr. MacCornack, Dr. Paul D. Sanders, Richmond, editor of The Southern Planter, painted a rosy picture of improvements in southern agriculture and was the south's best salesman at the conference. "It made me think," said Dr. MacCornack, "of the opportunity that awaits us when this crowd comes to Wisconsin in 1955."

Dr. MacCornack was interested in a talk by R. E. Short, vice president of the American Farm Bureau Federation, Brinkley, Arkansas. Mr. Short said that farm output is increasing in spite of the decrease in farm population, so that 11 per cent of our population now produces food and fibre for our entire nation and supplies the hungry of other nations as well.

Dr. MacCornack reached a number of conclusions as a result of his conference experience, to wit:

1. That the Council on Rural Health of the American Medical Association is rendering a distinct service to the health and welfare of rural people and that the conferences are real inspirational powerhouses, as well as forums for the exchange of ideas.

2. **That Wisconsin has not projected itself into the work of the Council on Rural Health in proportion to its rightful position and that having the conference in Milwaukee in 1955 will give us the opportunity to correct this.**

3. That Wisconsin should be well represented at the 1954 National Rural Health Conference in Dallas, in preparation for Wisconsin's big chance in 1955.

DODGE COUNTY SOCIETY CONFERS WITH NEWSMEN ON CODE OF PRESS RELATIONS

Waupun, March 1.—The Dodge County Medical Society recently arranged a dinner meeting with the editors of newspapers in Dodge and the neighboring counties in order to lay plans for a uniform procedure in giving information to the press.

The meeting was arranged by Dr. Leonard Schrank, chairman of the society's public relations committee, and his committee members, Drs. R. R. Roberts and Richard Way. Dr. Howard Bayley, president of the society, presided, briefly outlining the plans and purpose of the meeting and presenting Byron Ostby, Field Secretary of the State Medical Society who led the discussions.

A code of procedure was discussed point by point, with both newspapermen and physicians giving their views on matters that were controversial. The code was based on one prepared by the Cleveland, Ohio, Hospital Council, the Cleveland Academy of Medicine and the press of that city. One of its sections prohibits stating whether an accident patient was intoxicated or otherwise. Another places responsibility for giving out information at a hospital upon some one member of the hospital staff to whom all inquiries should be directed.

It was generally agreed that newspapers in the area had had no trouble getting necessary information from physicians regarding accident cases, and editors were given to understand that patient-physician relationships are privileged information except in "police cases." The conclusion was reached that the Cleveland code was satisfactory to all.

Additional discussion covered the release by physicians of information regarding new drugs, epidemics and other news not classified as privileged. Also touched on were the use of the title "Doctor" by persons not legally entitled to the designation, and the proper policy in regard to printing the names of polio patients where a definite diagnosis has been made.

In addition to physicians and newspapermen, law enforcement officers, coroners and superintendents of various hospitals in the area attended the meeting.

DR. LEONARD SCHRANK

Life Companies Urged to Branch Into Other Fields of Insurance

New York, Mar. 4.—Life insurance companies are being urged to branch out into the medical, health and accident insurance business by Charles J. Zimmerman, Hartford, Conn., managing director of the Life Insurance Agency Management Association.

In addressing the 46th annual meeting of the Life Insurance Association of America in December, Mr. Zimmerman said that disability insurance is a "fundamental form of personal insurance" and life companies have a "major responsibility" to provide it.

"Failure to provide coverage for accident and sickness, hospital, surgical and medical expense, and the catastrophic illness field, not only invites others to fill the gap, but creates public demand that others do so," Zimmerman said.

Zimmerman warned that life insurance sales in recent years have not kept pace with population growth or the increase in income.

"Life insurance has been losing ground to other forms of security expenditures in getting its share of the security expenditure dollar," he declared.

New life insurance purchases in 1952 totaled about 33 billion dollars, according to Bruce E. Shepherd, association manager. That is 12 per cent above last year's total and 7 per cent higher than the previous record year of 1950.

Commission Will Make Federal–State Study

Washington, March 1.—A bipartisan commission of Congressional, federal and state officials has been authorized to make an extensive study, then recommend legislation, on federal-state relations in the fields of taxes, health and social security.

Its membership will include representatives named by the President plus others designated by Congress and the State Governors' Conference.

The commission which originated at a White House meeting February 26 was an idea first advanced by General Eisenhower and Senator Taft last November. It is expected to complete its work within a year.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

615 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

A FORUM FEATURE

COMMUNITY TEAMWORK PAYS

HOSPITAL COUNCIL SOLVED AGENCY PAYMENT PROBLEM

By DAVID REYNOLDS
Administrator, Madison General Hospital

The formation of the Madison Hospital Council has been the answer to the third party agency payment question in this town.

Madison hospital administrators, like many others in the state, I venture to say, were unhappy about payments their hospitals were receiving from various welfare agencies for "charity" cases.

Hospitals Under Contract

The three voluntary general hospitals in Madison had been operating under a contract signed in 1949 with the City of Madison Welfare Agency and the Dane County Department of Public Assistance. This contract was rendering to the hospitals 60 to 75 per cent of the hospital costs, the revenue from these welfare agencies fixed at a per diem payment of $8 plus certain other allowances for operating room charges, x-ray, a few of the more expensive drugs and an occasional other type of payment determined by the agency.

This necessitated not only the employment of a full-time person to compute agency billings from standard hospital billings, but also meant much hasseling in order to establish the maximum amount of what the welfare agencies would allow or pay toward a given hospital illness.

Relationship Cordial

I wish to explain at this point that while our billing and payment arrangements with the two main welfare agencies were laborious and clumsy, our relationships with the directors and personnel of these agencies were most cordial.

The contract expired in 1951, and yet our hospitals allowed it to continue in force for another twelve months because, again, we found it easier to whine than do anything about it. However in April of 1952, the problem of patients being admitted to Madison hospitals with various types of partial-pay hospital insurance became so overwhelming that Miss Grace Crafts, former administrator of Madison General Hospital, initiated an informal meeting of several of the hospitals in the Madison area, in order to discuss the question.

DAVID REYNOLDS

It was immediately apparent that one meeting would not suffice because of the various areas of involvement, so others were scheduled on an informal basis with more hospitals being invited to attend. We very soon came to the conclusion that there was a definite need for this type of area hospital meeting. We adopted the name "Madison Hospital Council," and established regular monthly meetings, inviting all hospitals in Dane county to participate.

Constitution Adopted

The committee which was appointed to study the formation of the hospital council did considerable research and contacted existing hospital councils for suggestions and sample constitutions and policies under which we might organize. Over a period of 3 months, a constitution was proposed, modified and finally adopted. It was felt that this type of organization should be one of joint participation with no police powers to force any member hospital to adopt any policy foreign to its type of organization.

At the present time, the Madison Hospital Council is composed of voluntary general hospitals: St. Mary's, Methodist, Stoughton Municipal and Madison General; governmental: University Hospitals, which is a general hospital, Mendota State and Veterans Administration — specialist hospitals in mental and tubercular patient care respectively. Also members of our group are two sanatoriums, Lakeview and Morningside, both of which specialize in the care of the tubercular patient.

The purpose of the council is broad, and is quoted here: "The object of the Madison Hospital Council is to promote intelligent planning, coordination and cooperation in the field of community hospital service; to serve as a forum for the discussion of common problems and as a clearing house for the exchange of information for the advancement of hospital service; to interpret to the public the functions of hospitals and their place in the community; to cooperate with all agencies concerned with health and social problems; to promote united action in other matters."

Unity Results

As a direct result of meetings of the council, we have grown closer together. A feeling of each hospital, which in past years was at least independent, has been supplanted by mutual understanding and cooperation among us all. We have already felt favorable response from the community toward our organization.

In the early fall of 1952, Mr. Bert Miller, administrator of Methodist hospital, telephoned me and suggested we meet with representatives of St. Mary's hospital and investigate the possibilities of arriving at a new, more beneficial contract with the City of Madison and Dane county welfare agencies.

The directors of both agencies were requested to meet with us and hear our side of the story. When it was presented to them, it was their natural reaction that we were asking too much. We proposed straight hospital billing to the agencies less 5 per cent which each hospital could justify to the private paying patient as a collection expense.

During subsequent negotiations, a tragedy befell us in the untimely death of the director of the City of Madison Welfare Department. Mr. John Putz was a true public servant, a rare and unusual man who gave unstintingly of his energies to administer funds under his jurisdiction to the best interests of the purpose of the department and the taxpayers who

support it. Mr. Putz had succeeded in spading the ground with the City Council. It is largely due to his unceasing effort that a compromise was effected with the City Council of Madison and a new contract executed in January 1, 1953.

Approval of the proposed contract was given by the Dane County Board of Supervisors as a result of the logical appeal to them made by Mr. Allen Zoeller, director of the Dane County Department of Public Assistance. This contract provides payment by the agencies of complete hospital billing less a flat 10 per cent discount.

Disparity in Rates

One of the objections raised in our discussions was that each of the three hospitals in Madison has different rates for services and it would be to the advantage of the welfare agencies to choose the hospital which had the lowest rates for hospitalization of welfare patients. Upon further analysis of the hospitals' charges for equal lengths of stay in each of the three, it was determined, rather surprisingly, that the total hospital bill per comparable illness was just about the same in each of the three hospitals.

We immediately raised the point that should the welfare departments decide on a single hospital, it might limit, if not preclude, the patient's free choice of physician, and consequently of hospital. We pointed out the lack of ethics should this decision be reached, and once we had proved that the total hospital cost per illness was equitable in each hospital, the objection was dropped.

Difficulties Remain

At the present time the principle has been established, but there are the clerical difficulties and identification of services rendered and billed still to be resolved. However, it is now possible for each hospital to run a regular total billing on welfare patients and to subtract a flat 10 per cent from the total amount, which is a very short mechanical process and eliminates the arguing referred to formerly, over welfare patients' accounts.

Now, you say to youself, it is very fine that Madison has been able to do something. How does this affect me up in Ashland or Eau Claire or Sturgeon Bay, or where there is only one general voluntary hospital and we are stuck with accepting what the county boards will allow us? Why cannot we pass a law, you may ask, requiring each county board and each governmental agency to reimburse the hospitals, if not full billing, at least our costs?

David Reynolds came to Madison General Hospital five and a half years ago to serve a years internship in hospital administration, and stayed on to serve four years as assistant administrator. Last August he became administrator upon the retirement of Miss Grace Crafts. Mr. Reynolds received his undergraduate training at St. Mary's University, San Antonio, and his M. A. in hospital administration at Washington University, St. Louis. He saw four years of service in the Navy during World War II.

Community Relations

My answer to these questions is summed up in two words—community relations. It is my feeling that these relations remain even more sound and less affected in a small community than they are in a large small town such as Madison. It is a matter of salesmanship not only of the principle but of the personalities involved.

Each of us is acquisitive and selfish by nature, both for ourselves and for our employers. None of us, be we intelligently selfish as differentiated from unintelligently selfish, is able to attack this problem alone. Proper and thorough dissemination of information to our boards of directors, and, through them, to the citizens of the community, can result in presenting the hospitals' needs to this public.

We might take a lesson from the scholar who once said "I do not worry about who gets the credit for a job well done. I am only interested in that the job be well done." This must be an underlying principle of intelligently selfish hospital administration and goes hand in hand with the current question of payment from welfare agencies, both governmental and privately sponsored.

FDA BANS CANCER DIAGNOSIS KITS

Washington, Mar. 25.—A permanent injunction to stop further shipments of Dunkler's cancer diagnosis kit has been ordered by Federal Judge Philip L. Sullivan in Chicago, according to a report issued by the Food and Drug Administration of FSA. The Chicago manufacturer did not contest the court order.

The banned kit consisted of a test tube, a dish and two bottles of well-known chemicals. Directions were included which told the user to add the chemicals to a sample of the patient's urine and in an hour evaporate a medicine dropperful and observe whether a color change had occurred.

Dr. Gordon Granger, FDA medical officer, said the government's charges that the kit is worthless were confirmed by tests made by the M. D. Anderson Hospital, Houston. Tests were made on more than 100 known cancer patients and healthy medical students. Negative and positive results were obtained in both groups, and when the same individuals were retested, different results were obtained.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

PRIORITY III PHYSICIANS UP TO AGE 38 WILL BE CALLED TO ACTIVE DUTY

Madison, March 27.—Wisconsin State Selective Service has announced that Priority III physicians up to the age of 38 years are being called during the month of April.

Most of the physicians in Priorities I and II who are available and physically qualified for military service have already been called up. Most of those remaining as "essential" are currently in the last year of residency training, are serving isolated communities where the need of physician coverage is imperative, or are on the faculty of a medical school. All deferments on the basis of essentiality are temporary, however, and must be reviewed every six months.

Since the largest group of physicians affected by the so-called Doctor Draft Law are those in Priority III, the accompanying pay scale should be of interest. In addition to this scale, all physicians who voluntarily enter the service or are recalled as reserve officers receive $100 a month. All officers receive $47.88 per month as a subsistence allowance.

Therefore the total base pay may be computed by adding to the pay received for the rank assigned, the quarters allowance, subsistance allowance and the $100 monthly special allowance.

ARMED FORCES PAY SCALE

Army and Air Force	Navy	Base Pay	Quarterly Allowance Without Dependents	Quarterly Allowance With Dependents
2nd Lieut.	Ensign	$222.30	$ 85.50	$102.60
1st Lieut.	Lieutenant (jg)	259.36	85.50	102.60
Captain	Lieutenant	326.04	85.50	102.60
Major	Lt. Commander	400.14	94.20	119.70
Lt. Colonel	Commander	474.24	102.60	136.80
Colonel	Captain	592.80	119.70	136.80
Brigadier Gen.		800.28	136.80	171.00
Major Gen.	Rear Admiral	963.30	136.80	171.00

Well Construction Code Revisions are Initiated

Madison, March 2.—The first step toward revision of the state well construction code has been taken by the State Board of Health. New amendments take effect 30 days after official publication and approval by the governor.

The construction of new well pits, previously banned, will now be authorized if a permit has been issued by the board.

The revised regulations provide that existing well pits adequately drained or known to have been continuously dry are acceptable even though the walls are of cement block, brick or stone masonry.

Where ground water gains access to the pit that is not properly drained, an automatic sump pump is required as a safeguard. A three year period is set as the time allowed for the improvement of sub-standard pits and pump installations.

Enrollment in Nursing Schools Shows Increase

New York, March 6.—Schools of professional nursing in the United States admitted 42,103 new student nurses in 1952, according to Miss Theresa I. Lynch, chairman of the Committee on Careers in Nursing of the National League for Nursing, which conducts the national student nurse recruitment program. The figure for 1951 was 41,667.

Twenty-five states reported increased admissions last year over the preceding year, with the East North Central and Middle Atlantic states showing the largest gain. Wisconsin had 1,026 enrolled, as against 946 the previous year.

Miss Lynch termed the increase encouraging because it marks the beginning of a gradual rise in nursing school admissions which may be expected over the next few years as the population in the 17–18 year old age bracket increases.

Physicians Alerted to Watch for Statements Derogatory to Medicine

Madison, March 28.—The AMA is urging individual physicians and county medical societies to be on the alert for statements unfavorable to medicine which sometimes appear in the press, both in news and editorial pages, in speeches and on the radio.

Dr. George F. Lull, secretary and general manager of the AMA, has communicated with each of the state medical societies, in accordance with the wishes of the House of Delegates as expressed at the clinical session last December.

Text of Letter

The full text of his letter follows:

"During the clinical session of the association in Denver, the attention of the Board of Trustees was called to the fact that, in some areas, it is customary for physicians to watch for statements unfavorable to medicine in, say, editorials and speeches. As soon as one of the physicians learns of the remarks, he seeks the person responsible and attempts to impart truthful information. This action has, in some instances, resulted in public retraction of the statements.

"The Board of Trustees approved of this idea in principle and believes that it can be implemented with success on the local level."

The State Medical Society suggests that physicians follow this policy, and whenever they desire more information on a particular subject, they are urged to contact the SMS office for assistance. The State Medical Society would also appreciate receiving clippings or other notification of such instances.

21 New Hospitals Now Supply 929 Added Beds

Washington, D. C., Feb. 26.—Latest figures on Hill–Burton hospital construction in Wisconsin show that three projects which will supply 74 additional beds have been approved but are not yet under construction.

A total of 21 projects supplying 929 beds have been completed and are in operation. Fourteen more, which will add 758 beds, are under construction.

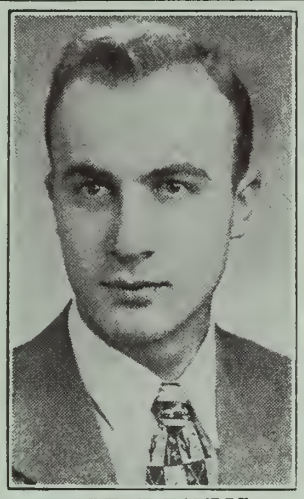
MARQUETTE HAS LARGEST SAMA CONVENTION DELEGATION

Milwaukee, March 26.—The Marquette chapter of the Student American Medical Association had the largest delegation at the 1952 SAMA convention which took place in Chicago the end of December. In addition to Robert Pavlic, delegate and Robert McNamara, alternate, 15 members of the chapter attended as observers.

Several delegates and national officers commented on the enthusiasm of the Marquette chapter. Russell Staudacher, executive secretary of SAMA, remarked to some of the group, "You have an unbelievably active chapter which seems to be just one jump ahead of the pack."

The convention acted upon various recommendations and resolutions as follows:

1. **Approved of a matching plan for internships.**
2. **Recommended a point system for drafting physicians, with points based on past service, length of time in practice, training, etc.**
3. **Recommended synchronization of draft calls with training programs in hospitals.**
4. **Recommended that medical schools offer courses in medical ethics, that chapters offer programs for cultural and historical study of medicine, survey student opinion on preceptorships and explore methods of financing a student's medical education.**
5. **Recommended that chapters cooperate with the Armed Forces in blood programs.**
6. **Suggested that state and county medical societies provide speakers for chapter meetings.**



ROBERT PAVLIC

Among the speakers at the meeting were Dr. C. C. Pfeiffer, Chicago; Dr. Howard Schriver, Cincinnati, president of the National Blue Shield Commission; Dr. Walter C. Alvarez, formerly of the Mayo clinic; Leo Brown, public relations director of the AMA; Dr. John D. Van Nuys, dean of the Indiana School of Medicine and several others.

The Marquette chapter has expressed deep appreciation to the State Medical Society for financing the official Marquette representatives to the convention. Dr. Joseph S. Devitt, Milwaukee, serves as adviser to the group.

Other Milwaukee doctors who have been working with the SAMA are John McCabe, who represents the county society; Joseph Majewski and Weston Gardner, faculty advisers.

The SAMA now has 59 chapters in 79 medical schools and expects to have 16,000 members by the end of 1953.

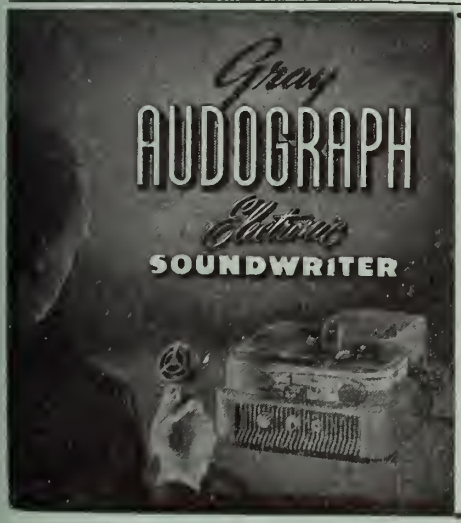
SKILLED LABOR, PHYSICIANS GET COMPARABLE PAY

Rutherford, N. J., Mar. 5.—The typical physician and the skilled laborer get hourly returns that are roughly comparable, according to the magazine Medical Economics.

A recent survey of income of the magazines' physician readers indicated an average net income, before taxes, of $14,098 a year. The magazine computed the hourly pay on the basis of time-and-a-half for overtime and double-time for Sunday work.

According to the survey, the family doctor works an average of 62 hours a week. Twenty-two of these must be counted as overtime and five represent Sunday work. For pay purposes, therefore, he would be credited with about 75 hours a week, or 3,750 a year, making his hourly pay come to $3.76 an hour.

The magazine observes that "the interesting thing about this figure is its strong resemblance to current base pay for skilled union labor. Many bricklayers, for example, get $3.25 an hour nowadays. And if other workers earn less and medical specialists earn more, isn't this explainable in terms of degree of specialized skill?"



A PROVEN AID FOR MDs

The GRAY AUDOGRAPH is not an experimental machine for doctors. Hundreds in and around Wisconsin are using it with complete satisfaction, as a means of speeding up their office work and increasing the efficiency of their secretarial help.

A Few Users in Madison . . .

STATE MEDICAL SOCIETY
DIV. MENTAL HYGIENE, DEPT. OF PUBLIC WELFARE
AMERICAN BOARD OF INTERNAL MEDICINE
WISCONSIN DIV., AMERICAN CANCER SOCIETY
JACKSON CLINIC — VA HOSPITAL
ALBERT BONER, M.D. — WILLIAM LEWIS, M.D.
STUART McCORMICK, M.D. — RAY LUDDEN, M.D.

Let us demonstrate how this machine can serve you. No obligation . . . let us know what time and day would be most convenient. A representative is near your office.

JOHN NICHOLS, Inc.
541 N. BROADWAY — MILWAUKEE 2, WIS.

HUDSON MEMORIAL HOSPITAL

Community Effort, Not Federal Funds, Built New Hudson Memorial Hospital

Hudson, Wis., Feb. 24.—A new 32-bed hospital in a community of 3,500 people, built without a penny of federal aid—that is Hudson Memorial hospital which opened its doors this month. It climaxes seven years of effort made by citizens of Hudson and surrounding towns.

Administrator of the new hospital is William C. Hale, former head of the hospital in Tomah. Chief of staff is Dr. G. E. Bourget, Hudson, while Dr. J. E. Newton, Hudson, is vice president and Dr. Chalmer Davee, River Falls is secretary.

Other staff members include Drs. M. G. Anderson, M. A. Cornwall, G. J. Hopkins, J. W. Livingston and Charles J. Neubel, all of Hudson; P. H. Gutzler and P. S. Haskins, River Falls and Carnot H. Sherman, Bayport. All are practicing physicians and surgeons in the area the hospital will serve.

The project got its start in 1946 when Mr. and Mrs. Stephen C. Phipps of Hudson established a fund of $70,000 to erect a community hospital as a memorial to Mr. Phipps' father. Mr. and Mrs. Charles A. Ward, Hudson, added cash gifts totalling $50,000 and the city of Hudson donated the hospital site and $40,000 of receipts from the interstate toll bridge across the Mississippi.

The remaining funds, over $300,000, came from hundreds of people living in and around the town. Citizens also gave generously of their time, grubbing trees and clearing brush to improve the site and the view. Teen-agers pitched in to clean up the interior of the building and put materials in storage.

Police Station Relays MD's Emergency Calls

Harrisburg, Pa., March 25.—One of Pennsylvania's county medical societies has taken care of its emergency call problem by a unique collaboration with the local police department.

It works like this. Three physicians are on call for a week at a time. They rotate the order of call each month and the names and telephone numbers are published in the local paper and are posted at the police station. The police station takes the responsibility of locating the physician if the caller so desires. It all adds up to good public relations not only for the physicians but for the police department as well.

FOWZER IS UP TO OLD TRICKS AGAIN

Chicago, Jan. 26.—Physicians in the east and mid-west are receiving announcements of a postgraduate course offered by Lloyd Fowzer, M. D., and the Farnsworth Laboratories, Inc., Chicago, according to the AMA Bureau of Investigation.

Dr. Fowzer, who dubs himself the "dean of diagnosticians," offers, among other things, a two-day "symposium in daily office and bedside diagnosis," for $50.

Dr. Fowzer is an "old timer" in the Bureau of Investigation files, according to Oliver Field of the bureau. His signatures appeared variously on diplomas sold in 1910 by the non-existent "Crescent Medical University" of Chicago, whose promoters became involved in mail fraud charges. In 1928, information was received that he was selling "wild horse serum" as a cancer cure.

Fowzer practiced at one time in Wisconsin, but was reported to have abandoned his Milwaukee practice in 1931 to sell stocks and bonds. He came to the attention of the bureau as recently as 1950 when he was scheduled to appear at the "commencement" of a Chicago diploma mill—the McCormick Medical College.

AMA Scores Again With Radio Broadcast Series

Madison, March 30.—A series of public service radio programs entitled "Medicine, U.S.A." has been presented this spring by the American Medical Association over the NBC network.

Patterned after the series which was so well received a year ago, "Medicine, U.S.A." consisted of six half-hour broadcasts featuring well-known radio, screen and stage stars, including Pat O'Brien, Claude Raines, Helen Hayes, Robert Preston, Kim Hunter and H. V. Kaltenborn.

The series was carried by the following Wisconsin stations:

WKBH _____La Crosse
WIBA _____Madison
WMAM _____Marinette
WSAU _____Wausau

Subjects covered were problems of old age, rural health, gifted children, deafness, arthritis and cancer.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Questions and Answers Suggested by Recent Investigations in Drug Therapy

What distinction should be made in the types of acute pulmonary edema when contemplating treatment by the inhalation of alcohol vapor? Pulmonary edema is potentially associated with any systemic alteration causing hypoxia, which increases capillary permeability and allows proteins to escape from the blood into the interstitial spaces, where they attract and hold water and salts. If the amount of fluid thus accumulated exceeds the capacity of the lymphatics to return it to the general circulation, the patient becomes edematous. If the effectiveness of the new approach to treatment of this state through inhalation of alcohol vapors, as developed by Luisada[1] is confirmed by independent investigators, I imagine it will be helpful in any type of pulmonary edema associated with the hypoxic state. On the other hand, while the alveoli also fill with frothy mucus in the type of pulmonary edema resulting from lung traumatization through blast or direct injury by the action of chemical or hot fumes, there is here the added factor of increased pulmonary and bronchial secretory activities. Atropine or scopolamine in usual dosage is required to meet this latter situation.

What eye disease contraindicates the use of Banthine? Being a true anticholinergic agent, Banthine has an inhibitory effect on the action of acetylcholine in the autonomic ganglia, both sympathetic and parasympathetic, and at the parasympathetic postganglionic nerve endings. It may therefore cause difficulty in emptying the bladder, particularly when there is an enlarged prostate or bladder neck obstruction. It may also cause difficulty in defecating and may even stimulate the higher centers. Specifically in answer to this question, its use is contraindicated in glaucomatous individuals because it will have an effect upon the pupil and the ciliary body precisely like that of atropine.

To what things particularly should one be alert when using ACTH or cortisone in the treatment of bronchial asthma? Baldwin and deGara[2] have offered evidence indicating that in the use of these two drugs in allergic maladies it may be necessary only to return the eosinophils to normal levels. This might prove to be a practical guide to satisfactory dosage. Even though dosage may be reduced through use of this criterion and no serious side effects are noted, it is of the utmost importance to be alert to the masking effects of cortisone and ACTH on pain and acute intercurrent infection. Furthermore, these drugs must be used with great caution, if at all, in hypertension, diabetes mellitus, coronary disease, and psychopathology.

How might one explain the enhanced hematopoietic responses to combined oral doses of folic acid and vitamin B_{12} (in themselves suboptimal) that Reisner and Weiner[3] alleged to occur in some pernicious anemia patients? In pernicious anemia adequately treated with liver extract, a carrier of vitamin B_{12}, a hematologic response does not occur if a folic acid antagonist is simultaneously administered. This means, of course, that folic acid is necessary for the maturation of erythrocytes. Vitamin B_{12} seems to enable the folic acid to effect maturation by facilitating the necessary degradation of its conjugates. It should therefore perhaps not be entirely surprising that a full folic acid effect is achievable if only a small "potentiating" amount of vitamin B_{12} is absorbed—HARRY BECKMAN, M. D.

REFERENCES

1. Luisada, A. A., Goldmann, M. A., and Weyl, R.: Alcohol vapor by inhalation in the treatment of acute pulmonary edema, Circulation 5:363–369 (March) 1952.
2. Baldwin, H. S., and deGara, P. F.: Hospital and ambulatory treatment of asthma and eczema with ACTH and cortisone, J. Allergy 23:15–26 (Jan.) 1952.
3. Reisner, E. H., and Weiner, L.: Studies on the mutual effect of suboptimal oral doses of vitamin B_{12} and folic acid in pernicious anemia, New England J. Med. 247:15–17 (July 3) 1952.

UNIVERSITY OF MINNESOTA ANNOUNCES CONTINUATION COURSES

The Center for Continuation Study at the University of Minnesota Medical School will present three courses for general physicians during the month of May: Surgery, May 7–9; Arthritis and Allergy, May 11–13; and Radiology, May 21–23.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Madison, Wisconsin

Cardiac Arrest in the Pediatric Patient

Cardiac arrest presents the greatest possible emergency and potentially is one of the most disastrous events that may occur in medicine. It is most frequently an operating room accident because circumstances of anesthesia, regardless of type, and surgery predispose to its development.

Safety in anesthesia depends largely upon the degree of watchful care and judgment exhibited by the administrator of an anesthetic agent. Likewise, every physician performing an operation must be prepared to deal with emergencies without a moment's hesitation. Experience in the recognition and treatment of difficulties creates judgment in an individual. Whenever possible, particularly when the well-being of a patient is at stake, it behooves all to learn from the experience and mistakes of others. For each one to develop discernment by personal contact would be an unreasonably long and costly procedure.

The Wisconsin Anesthesia Study Commission has selected two cases which demonstrate the importance of attention to minute details and the necessity for instantaneous treatment of cardiac arrest. You are invited to participate by submitting comments or case reports of errors, difficulties, or fatalities during anesthetizations. Complete anonymity is maintained.

CASE 43—A 5 year old boy was admitted to the hospital for surgical correction of bilateral exophoria. Significant facts in the past history included premature birth at 7 months, a Ramstedt operation for pyloric obstruction at 6 weeks of age, and rather severe responses to the childhood diseases.

Preoperative examination was normal, and he received 0.43 mg. of atropine hypodermically and 60 mg. of nembutal rectally one hour before the surgical procedure. Induction was accomplished with nitrous oxide-oxygen mixture followed by ether using a Heidbrink circle machine. Maintenance was continued with ether vaporized by air and blown through a mouth hook using a suction pressure machine.

The operation proceeded uneventfully for about one-half hour. The patient's breathing was rather deep and rapid, and the ether was administered intermittently. It was noted that each time ether was added to the air mixture there was momentary apnea and then resumption of respiratory activity without difficulty. Mucous accumulation in the throat was aspirated by a catheter inserted into the pharynx. Immediately after the catheter was withdrawn, breathing stopped and the patient became cyanotic. Shortly after the cessation of respiration, the pulse, which had been of good quality and regular at 140 beats per minute, became imperceptible. Oxygen was given through the ether hook until approximately 3 minutes later, when good, positive artificial respiration was established by the use of manual compression on a breathing bag with mask. Since there was no improvement in the child's condition, the chest was finally opened and cardiac massage instituted. Eight to 10 minutes had elapsed since breathing had stopped. The child gradually responded with apparently normal respiratory and cardiac activity but did not regain consciousness. Death occurred about 12 hours later.

Postmortem examination revealed a "wet brain" with engorgement of the capillaries and one hemorrhagic adrenal gland. There were no cardiac abnormalities.

CASE 44—After induction with open ether, a 20 month old infant was intubated with a number 2 Magill portex endotracheal tube and a pharyngeal pack was put in place. No preoperative medication had been given. Ether-oxygen anesthesia was continued by the closed circle technic using a child-size face mask over the endotracheal tube. A standard-size number 9B Heidbrink canister, capacity 500 cc., was in place, and the oxygen flow was approximately 500 cc. per minute.

Thirty-five minutes after induction, repair of a pectus excavatum was started. The patient's color was good, respirations were full and deep, and the pulse rate was 140 beats per minute. Thirty minutes later, very slight twitching of the infant's fingers was noted and his color was dusky. Oxygen flow was increased and the ether turned off. There was some improvement, and five minutes later at 9:45 a.m., the circle technic was replaced by to-and-fro closed technic and ether was added again to the mixture for several minutes. The twitching returned with greater severity and cyanosis was definite. At this time an anesthetic flow of 500 cc. of oxygen and 500 cc. of nitrous oxide was being given. Respirations were assisted by manual compression of the bag with no improvement in the patient's condition. At 10:05 the technic was changed back to the circle system and assisted respiration maintained, using almost 100 per cent oxygen. Mild cyanosis persisted. At 10:25, 45 minutes after the first twitching was

noted, cardiac arrest occurred, followed by respiratory arrest. The surgeon was informed and direct cardiac massage was instituted within 1 minute. Artificial respiration with 100 per cent oxygen under positive pressure was maintained continuously. The heart was massaged for about 2 minutes, at which time ventricular fibrillation was observed. Five cc. of 2 per cent procaine solution was instilled into the pericardial sac, and cardiac massage was continued while a defibrillator was being made ready.

The fibrillation ceased spontaneously, however; and 6 minutes after the initial arrest good cardiac rhythm and normal respiratory excursions were reestablished. Distention of the stomach was relieved by insertion of a Levine tube and the operation was resumed.

Significantly, a right pneumothorax occurred early during the repair of the right side of the costal margin. A left pneumothorax occurred just before cardiac arrest was noticed. The patient was kept in the operating room until he had fully awakened and was moving about quite actively.

He was discharged after a normal postoperative recovery period, and at the present time, as far as can be determined by observation and behavior, he is entirely normal in every respect.

Comments

Anoxia is the most common cause of death in anesthetized children. Because of the relatively narrow diameter of the trachea and bronchi and the small size of the laryngeal opening, a minor obstruction in the upper respiratory tract may precipitate grave trouble. The reserve air space in the lungs of a child is not large, and the oxygen may be rapidly exhausted by transfer to the blood stream. Moreover, circulating blood volume is small, resulting in a rapid arterial oxygen depletion unless there is a constant flow of oxygen across the alveolar membranes.

Potential sources of trouble which may rapidly alter pediatric physiology include the following:

(1) obstruction of the airway, (2) mechanical dead space, (3) accumulation of carbon dioxide, and (4) resistance in anesthetic apparatus.

Obstruction to the airway accounted for most of the difficulties precipitating cardiac arrest in case 43. Apnea, which occurred with each addition of ether, may have been a protective breath-holding response of a lightly anesthetized subject to irritating vapor. Breath-holding may lower arterial oxygen saturation to dangerous levels in the short period of 30 seconds. Once induction had been accomplished, anesthesia was maintained without the benefit of increased oxygen, which was an additive factor in permitting anoxia to develop.

To avoid the possible tragic consequences of hypoxia, the oxygen content of the anesthetic mixture must always be kept adequate, especially during induction when disturbances in respiration are most frequent.

The second case demonstrates the inadvisability of increasing dead space with anesthetic apparatus and subjecting the weak respiratory musculature of a child to the effort of overcoming the resistance of absorption apparatus. The small tidal exchange in children, normally about 200 cc., is often lessened by depressed respiration under anesthesia. The resistance inherent in the accordian tubes, directional valves, and soda lime of a circle apparatus measures 5 to 8 mm. of water, while that of a to-and-fro apparatus varies from 2.5 to 3 mm. of water. It is unwise to subject a child to either technic unless adequate assistance is given to the respiratory exchange throughout the entire procedure. It is of paramount importance to assist respiration by applying light (5 to 7 cm. water) pre-inspiratory pressure to each respiration while the chest is open. Even the smallest face mask may increase considerably the total dead space. The space in the mask and connecting pieces is out of proportion to the tidal volume. The twitching, probably caused by the retention of carbon dioxide which is a concomitant factor with increased dead space, was the first warning sign of impending danger. Change-over to a to-and-fro absorption system did not alter the conditions appreciably. Assisted respiration was started too late to overcome the hypoxia caused by fatigue, inadequate expansion, low gas flow, and increased dead space. The surgical pneumothoraces completed the anoxic sequence, and cardiac arrest occurred.

The most recent method to be utilized in pediatric anesthesia, with relatively low disturbance of physiology, incorporates a valvular arrangement in which all the exhaled gases are moved from the system. This eliminates the hazard of carbon dioxide accumulation by rebreathing and obviates the strain of resistance. To reduce dead space the valve is connected directly to an endotracheal tube. On the other end of the valve a 2.5 liter reservoir bag is placed, and the distal end of the bag is connected to the source of gases. If respiration becomes depressed or inefficient, assistance can be rendered or control established without difficulty.

The contrasted outcome of these cases illustrates the absolute necessity of prompt recognition of cardiac arrest and its immediate treatment. The time available for restoring circulation without irreversible damage to brain cells is considered to be not more than *three* minutes. In the first case reported, 8 to 10 minutes elapsed before cardiac massage was initiated. The prime requirement in the emergency situation of cardiac arrest is the maintenance by artificial means of an adequate transport system, namely ventilation and circulation.

The airway must be unobstructed, and this can be best assured by insertion of an endotracheal tube. Adequate pulmonary ventilation at a rate of 16 to 30 times per minute is maintained by intermittent manual positive pressure and release on a bag inflated with 100 per cent oxygen, with provision for removal of carbon dioxide either by absorption or frequent refilling of the anesthetic bag with fresh oxygen. If oxygen is not available, air or even the

exhaled breath of the operator may be used. Carbon dioxide should not be added to oxygen used for resuscitation, because the patient whose respiration has ceased is already unable to eliminate carbon dioxide retained in his blood and tissues.

Cardiac massage is the most efficient method of providing artificial circulation. Direct approach is made through the chest wall by a transverse incision in the fourth left intercostal space with division of the fourth and fifth costal cartilages. Effective blood flow is obtained when the heart is grasped between the fingers and thumb of a hand and compressed at least 60 times per minute. Extensive preparation and draping of the chest or waiting for instruments to be sterilized have no place in the procedure. The surgeon should never hesitate in opening the thorax simply because he has never had any experience with that type of operation. Speed rather than asepsis is the essence of success. When ventricular fibrillation exists, the recommended treatment is serial defibrillation. The use of analeptic or sympathomimetic drugs in cardio-respiratory emergencies is to be condemned. These drugs increase oxygen demand and aggravate the danger of damage from anoxia. Very dilute adrenalin solution given slowly may initiate pacemaker activity.

Development of hypoxia with its tragic sequelae in the pediatric patient can be avoided only by constant watchfulness of the airway and meticulous attention to technic. Not only must one insure that adequate oxygen is being supplied in gaseous mixtures; but one must also ascertain that there is sufficient unobstructed tidal exchange to allow that oxygen to reach the blood stream during every minute of the operation.

2409 Kendall Avenue, Madison.

REFERENCES

1. Stephen, C. R.: Technics in pediatric anesthesia—The nonrebreathing method, Anesthesiology 13: 77 (Jan.) 1952.
2. Stephen, C. R.: Operating room fatalities in pediatric surgery, Current Researches in Anesth. and Analg. 31: 36–44 (Jan.–Feb.) 1952.
3. Bonica, J.: Role of anesthesiologist in management of cardiac arrest, Current Researches in Anesth. and Analg. 31: 1–18 (Jan.–Feb.) 1952.

SPRING SCIENTIFIC SESSION OF THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

The spring scientific session of the Wisconsin Society of Anesthesiologists will be held Sunday, May 17, beginning at 10:00 a.m., in Room 306 of the Wisconsin General Hospital in Madison.

PROGRAM

10:00 Personal Experiences with Group Practice
Willard D. Bennett, M. D., Louisville, Kentucky

10:15 Distribution and Rate of Metabolism of Thiopental (Pentothal)
Fred Shideman, M. D., Professor of Pharmacology, University of Wisconsin, Madison

10:45 Round-Table
Hypotension during Anesthesia: Blessing or Catastrophe?
Chairman: O. S. Orth, M. D., Madison
E. C. Albright, M. D., Madison—Internist
R. A. Tella, M. D., Wood—Anesthetist
Charles W. Crumpton, M. D., Madison—Research
W. B. Youmans, M. D., Madison—Physiologist

12:00 Luncheon (Hospital cafeteria available. Reservations unnecessary.)

1:30 Round-Table
Trichlorethylene: Solvent or Anesthetic Agent?
Chairman: L. G. Kilpatrick, M. D., Madison
Leroy Sims, M. D., Madison—Effects on Liver
Allen Wheeler, A. B., Madison—Effects on Heart
Carlos P. Parsloe, M. D., Madison—Clinical Use

2:30 Current Questions

Changes in Medical Policies of the Wisconsin Anti-Tuberculosis Association

O. A. SANDER, M. D.
Chairman, Medical Policies Committee, WATA

A. A. PLEYTE, M. D.
Medical Director, WATA

FOR over 30 years the medical department of the Wisconsin Anti-Tuberculosis Association has been engaged in many educational activities in the continued fight against tuberculosis. This is in accordance with the established policy of the WATA that certain medical projects may be set up as demonstrations with funds raised through the sale of Christmas Seals. In such instances, it is intended that the projects be transferred to official or other agencies or individuals after a reasonable period of time.

Some of the projects of the WATA medical department, such as "Sanatorium Consultation Service," "Chest X-ray Film Interpretations," and "Fluoroscopic Chest Clinics," have been carried on longer than necessary for demonstrational purposes.

It is the intent of the board of directors of the WATA that the demonstration projects carried on by its medical department should be absorbed as soon as possible, thereby permitting the WATA to expand into other educational programs.

When more projects are taken over by official agencies and new projects are demonstrated in place of the old, there will be much more activity in the over-all campaign against tuberculosis.

Chest X-Ray Film Interpretation

When this service was started, Wisconsin had relatively few radiologists trained in chest x-ray film interpretation and few full-time sanatorium physicians. It was quite natural for WATA physicians, who had been closely associated with the clinical phases of tuberculosis and the early discovery of this disease, to interpret such films. It is believed that this service has been useful and may continue to be useful in communities where roentgenologists, phthisiologists, and internists are few or nonexistent. However, it is felt that in most communities in this state either radiologists or sanatorium physicians can take over this service.

Chest Clinics

Only one fluoroscopic chest clinic is still being conducted on a regular basis by a WATA physician. All others have been transferred to local health departments.

Tuberculin Testing Surveys

These surveys have been conducted by the WATA in Wisconsin schools, often with the help of local physicians. Reactors are screened out and receive miniature chest x-ray films. It is hoped by the WATA board of directors that practicing physicians, sanatorium physicians, or school physicians in Wisconsin will take over this service as soon as possible.

Sanatorium Consultation Service

Medical consultation service has been given to several Wisconsin sanatoriums for many years at intervals of two weeks to two months. No one has questioned the value of this service. However, it is believed that this service can and should be carried on by other physicians, including full-time sanatorium physicians and doctors specializing in the diagnosis and therapy of chest diseases.

The board of directors of the WATA endorses sanatorium consultation service and authorized the medical director of the WATA to appoint a committee composed of representatives from the State Board of Health (Dr. Carl Neupert), the Wisconsin Trudeau Society (Dr. Joseph Gale), the Committee on Tuberculosis and Chest Diseases of the State Medical Society (Dr. John Steele and Mr. Roy Ragatz), the Wisconsin General Hospital (Dr. Helen Dickie), the Sanatorium Trustees Association (Rev. Chester Harries), the Sanatorium Superintendents Association (Dr. Raymond Evers), and the WATA (Dr. A. A. Pleyte). Dr. O. A. Sander, chairman of the WATA Medical Policies Committee, and Dr. Einar Daniels, secretary of the Wisconsin Trudeau Society, also attended meetings of this committee. Mr. John Hein, secretary of the Wisconsin Trustees Association, acted as secretary of the several meetings. This committee was asked to assist the WATA medical director in devising ways to transfer the medical consultation service to qualified physicians in Wisconsin.

A list of names of qualified physicians and surgeons to serve as consultants was secured from the medical directors of Wisconsin's 24 sanatoriums. These proposed consultants were asked (1) whether they would serve as consultants and (2) how much time they could spend in the course of one year.

This information was compiled and has been sent to sanatorium physicians, superintendents, and trustees.

The Committee on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin, acting in an advisory capacity, has reviewed the above statement of contemplated changes in the medical policies of the WATA and believes these changes are in the best interests of the anti-tuberculosis movement and the medical profession of the state.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWG	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

The patient was a 39 year old white female whose final admission to the hospital was in January 1950 with complaints of cough and dyspnea. Her illness had begun in September 1949 with a severe cough which was productive of a white foamy sputum, estimated at being a cupful daily. She had noticed no dyspnea, although her husband had thought that she was short of breath. She had received no medical attention until December 1949 when, in addition to her cough, dyspnea, swollen ankles, and pain in the wrists, elbows, and knees developed. At this time she entered the hospital, where diagnostic studies, including a bronchoscopic examination, were made. The bronchoscopic examination was reported as showing bronchial stenosis of the left lung. The patient was subjectively improved and sufficiently relieved so that she was able to leave the hospital in 10 days. After returning home, her symptoms reappeared and she felt somewhat worse. On returning to the hospital, she was given inhalation therapy, penicillin, and other medications. Her ankle swelling diminished but her cough persisted. She was again discharged, with instructions to stay in bed at home. Again after returning home she became worse. The dyspnea was now so severe that her nights were sleepless. There was considerable cough with difficulty in expectorating a thick white sputum. She now had pain and swelling in her ankles, knees, fingers, and elbows. Her chest was painful as a result of the cough. She had noticed some clubbing of her fingers since the onset of this illness. She had been told that she had a butterfly configuration on her face, but her husband stated that this had been present for many years.

Past history showed that she had contracted a cold in the winter of 1948 with considerable cough and expectoration. She was treated at this time with penicillin and recovered. Similar episodes occurred in 1947, were treated as above, and apparently subsided. In 1947 she was in Florida for the winter, at which time she contracted an illness with a high temperature. After she had returned home and stayed in bed for two weeks, her temperature subsided. There was no previous history of pneumonia, pleurisy, or exposure to tuberculosis. No history was elicited of allergy, hay fever, asthma, night sweats, afternoon temperature, or hemoptysis. There had been a weight loss of about 20 pounds since the onset of the present illness. Past surgical history included a hysterectomy 10 years before for cystic ovaries and menorrhagia. The patient smoked 40 cigarettes a day and drank occasionally. Review by systems was essentially negative.

Physical Examination. The blood pressure was 104/58, the pulse rate 128 and regular, the respiration rate 22 and labored, the temperature 99.2 F. The patient was an obese, short-statured female who sat erect in bed, was dyspneic, and was coughing. Over the bridge of the nose was a butterfly erythematous patch which blanched on pressure. There was a similar patch on the chin and over the manubrium. Examination of the head was essentially negative. Partial dentures were in place. The tonsils were atrophic; the throat was not injected. The chest showed equal expansion. There was dullness to percussion at the right base posteriorly with diminished tactile and vocal fremitus. Rales were heard throughout both lung fields. The absence of breath sounds was noted over the area of dullness. The left lung was resonant to percussion. Wheezes were heard over the entire left lung. The heart was not enlarged. The abdomen was soft; no masses or tenderness were present. Rectal examination was negative. The extremities showed clubbing of all fingers with minimal cyanosis of the nail beds. The elbow joints, as well as the knee and ankle joints, were painful, swollen, and warm to the touch. There was a 2 plus pitting ankle edema. Neuromuscular examination was negative. There was no lymphadenopathy. Pelvic examination was normal.

The patient was treated symptomatically. Thoracentesis was done on the second day of hospitalization. During the patient's stay in the hospital it was necessary to tap her chest repeatedly, since the fluid rapidly reaccumulated. She remained dyspneic throughout her hospital stay. Her cough persisted and was productive of a copious watery sputum.

Laboratory Work. Urine: specific gravity 1.017; albumin 10 mg.; sugar 0; acetone 0; microscopic negative. Blood: hemoglobin 11.5 Gm.; red blood cell count 3,690,000; white blood cell count 12,200; segmented 66; stabs 6; lymphocytes 23; monocytes 5; nonprotein nitrogen 33 mg. per cent; blood sugar 127 mg. per cent; total protein 5.3 Gm.; albumin 3.66 Gm.; globulin 1.64 Gm.; albumin-globulin ratio 2.2:1. Prothrombin time was 52 per cent; serology negative; sedimentation rate 114 mm. per hour (Westergren); bromosulphalein, 20 per cent dye retained at 45 minutes, 18 per cent dye retained at 60 minutes. Sputum showed the presence of staphylococci, streptococci, and a gram-negative bacillus belonging to the Friedlander aerogenes group. No

* From Milwaukee Hospital and the Department of Pathology, Marquette University School of Medicine, Milwaukee: **Dr. Frank Belfus** and **Dr. E. R. Daniels**, clinicians; **Dr. H. W. Hefke**, radiologist; and **Dr. Edward A. Birge**, pathologist.

eosinophils or fungi were found. Concentrated smears for tubercle bacilli were negative. Pleural fluid was negative for tubercle bacilli and for pyogenic organisms. Papanicolaou smears of the pleural fluid were negative. Bone marrow was normal.

Roentgenographic Studies. On admission there was an effusion in the right pleural cavity, reaching the level of the third anterior rib. The heart was displaced somewhat to the left. The left lung was normal. The mediastinum was normal. Reexamination of the chest after removal of the fluid showed that there was still some fluid present on the right. There was considerable congestion or pneumonic change in the lower half of the right lung with some congestive changes about the left hilus.

An electrocardiogram showed sinus tachycardia and questionable right axis deviation.

Dr. Frank Belfus: This is the history of a persistent unrelenting illness of at least four months' duration and probably of insidious origin for the previous one to one and one-half years. Our attention is at once directed to the respiratory system by the symptoms of productive cough, shortness of breath, pain in the chest, and by the findings of fever, cough, rales, wheezes, and right-sided effusion, as well as by clubbing of the fingers. The patient's history bears out the attention which her respiratory symptoms have merited. However, other systems appear to be involved in this disease. The knees, ankles, and elbow joints are inflamed in an arthritic process. We also note that there is a considerable tachycardia, mild cyanosis, ankle edema, orthopnea, and the presence of questionable right axis deviation in the electrocardiogram, indicative of circulatory embarrassment.

In the laboratory studies and special tests, we note that there is a moderate anemia, a mild leukocytosis, a slightly reduced total protein, a mild albuminuria, and a very highly elevated sedimentation rate. The sputum is of interest because of the presence of streptococci and Friedlander's bacilli and the absence of tubercle bacilli. The type of Streptococcus is presumably not identified nor is the quantity of Friedlander's organisms specified. These two points might be of some interest. The green streptococci are common inhabitants of the sputum, but the hemolytic Streptococcus should probably not be ignored as a pathogen. According to reports, the Friedlander's bacillus may be found in 2 to 25 per cent of normal persons, but the organism can be a dangerous pathogen in itself.

The roentgenograms should be of considerable interest. We have a history of a bronchoscopic examination showing bronchial stenosis of the left lung and then pleural effusion on the right side with a normal left lung. After removal of the fluid we are told that there is probably a pneumonic process in the lower right lung and some congestive changes about the left hilus.

Dr. H. W. Hefke: When the patient came to the hospital in January 1950 she presented the picture of a pleural effusion with displacement of the heart to the left. Because of the effusion on the right, the diaphragm was not seen. If the diaphragm had been elevated, one would think of atelectasis. In a woman of about forty it is hard to tell the significance of this. In older people most effusions are related to malignancy, *i. e.*, carcinoma or lymphoblastoma. If she were younger, in her twenties, tuberculosis would be more common, but at forty it could be either, and there is no way to tell in this particular film. There is no erosion or depression of the ribs, no enlargement of the heart. The process could be inflammatory. It could also be malignant. The x-ray, which was taken after some fluid had been removed, could not prove it. There is still a great deal of lung abnormality and some involvement on the left side.

Doctor Belfus: And then we are informed of the presence of a butterfly pattern on the face which presumably has been present for many years. We are naturally inclined to attempt to explain the woman's illness in terms of one single disease process. If we pay any attention to the presence of the facial butterfly we at once think of lupus erythematosus. Certain other parts of the puzzle seem to fall together to favor this diagnosis.

1. The patient is a relatively young white female.
2. The history of the patient's illness might well fit into a chronic pattern of exacerbations and remissions dating to 1947.
3. The presence of polyarthritis would be consistent.
4. Pleurisy with effusion might represent the typical serous surface manifestations of lupus erythematosus.
5. Anemia is consistent.
6. Heart failure is consistent.

However, for a diagnosis of chronic lupus erythematosus we would also like to see:

1. A butterfly rash of briefer duration and one which does not blanch easily on pressure.
2. Further evidence of direct heart damage or pericarditis, perhaps a murmur.
3. Evidence of glomerular damage (beyond 10 mg. of albumin as in this case). A heavy proteinuria plus the presence of red cells would be more consistent with the diagnosis.
4. We should also like to find some enlarged lymph nodes. These are present in about 50 per cent of the cases.
5. A leukopenia and thrombopenia might be expected and of course the bone marrow might reveal the presence of Hargrave's LE cells.
6. We would not expect to find the hand changes of pulmonary osteoarthropathy.
7. We would not expect to find evidence of focal lung disease, since lupus erythematosus is inclined to produce a predominantly diffuse interstitial and fibrosing pneumonitis, or to find what appears on the x-ray to be a bronchopneumonia pattern.
8. For the diagnosis of lupus erythematosus we should also like to see a reversed albumin-

globulin ratio with hyperglobinuria, especially in the acute phase of the disease.

Admittedly lupus erythematosus is a disease of wide clinical variation and its possible presence should not be lost sight of in this case. Two other disorders should be considered as well. What is the possible significance of the Friedlander's bacillus in the patient's sputum?

1. The patient's past history is suggestive of recurrent respiratory infection which would be compatible with the cause of chronic Friedlander's pneumonitis.
2. The sputum has been described as being rather copious.
3. The x-ray findings are compatible with the diagnosis of a localized pneumonic process which may be seen in Friedlander's infection, especially when there is delayed resolution or abscess formation.
4. Pleurisy with effusion is also fairly common in Friedlander's pneumonia, and nonsuppurative arthritis has also been noted.

Against this diagnosis are certain missing quantities:

1. The sputum of Friedlander's pneumonia is often hemorrhagic, tenacious, and glairy, the so-called "apple jelly" sputum.
2. The disease is usually seen in the upper lobes of the lung.
3. The organism is found in great abundance and often in almost pure culture.
4. Cardiac symptoms are not an ordinary feature of Friedlander's pneumonia.

A third possibility I wish to consider now, and the one which appeals to me most, is that of a neoplasm of the lung. The points which seem to favor this diagnosis are as follows:

1. There is a history of chronic cough, dyspnea with cyanosis, unilateral obstructive signs of wheezing, pain in the chest, and clubbing of the fingers.
2. The history would tend to place the disorder in the left chest, yet the x-ray suggests that most of the difficulty was in the right chest. This is difficult to explain except on the basis of associated vascular occlusion or extension of the neoplasm to that side.
3. The rapid reaccumulation of fluid after thoracentesis is typical of neoplasms of the lung.
4. Low-grade fever and bouts of high fever are the rule in carcinoma of the lung. They are likely to be the result of infection in the lung, which is often atelectasis, peripheral to the neoplasm.
5. Compression or actual invasion or thrombosis of the great vessels of the lung could easily produce pulmonary hypertension and some degree of heart failure compatible with this patient's history and findings.
6. Associated arthritis as a separate phenomenon must be postulated in this case and in fact is not uncommon in the presence of prolonged debilitating diseases and chronic infections.
7. To complete the picture it would be advantageous to have the record of blood-streaked sputum or the presence of blood in the pleural fluid. The absence of both of these signs, however, does not rule out carcinoma, although adenocarcinoma is probably less likely than other types.
8. Similarly, the presence of carcinoma cells in the Papanicolaou stains of the pleural fluid would be most helpful but their absence does not rule out this possibility.

I have excluded from the differential diagnosis such disorders as bronchiectasis, unresolved pneumonia, and lung abscess, perhaps unwisely. The possibility of metastatic carcinoma to the hilar area of the lungs cannot be ignored.

My clinical impression is as follows:

1. Malignant neoplasm of the lung—probably primary, possibly metastatic.
2. Associated symptoms: (a) pneumonitis, (b) pulmonary hypertension and right ventricular failure, and (c) rheumatoid-like arthritis precipitated by the patient's debilitating pulmonary disease.

Dr. P. F. Hausmann: Was the sputum profuse in amount?

Dr. E. R. Daniels: One to two cups per day of watery mucoid sputum were produced.

Dr. D. S. Thatcher: Could this have been Boeck's sarcoid?

Doctor Daniels: That is a perfectly logical diagnosis. Boeck's sarcoid can be very severe without any skin manifestations, can be limited to the lungs, and can give these general symptoms. It is proper to put this into the differential diagnosis.

Dr. Owen Royce: Was the sputum checked for pulmonary adenomatosis?

Dr. E. A. Birge: Pulmonary adenomatosis was one of the differential diagnoses considered at the time. Sputum examinations were made and examined for the cells of pulmonary adenomatosis. I was unable to find any such cells.

Doctor Hausmann: I have never seen pleural effusion with pulmonary adenomatosis.

Doctor Birge: At autopsy this patient was found to have lymphangitic carcinomatosis, primary in the lung. The clinical protocol contains all the essential features of the case for the first five or six days after admission. During the course of the patient's hospital stay, repeated pleural aspirations were made. Each of these was examined for tumor cells and in some of the later specimens I found cells which I believed were malignant. The cells were misinterpreted. They were large, very bizarre in shape, and often multinucleated. I thought that they might represent a choriocarcinoma. Since the pelvic organs

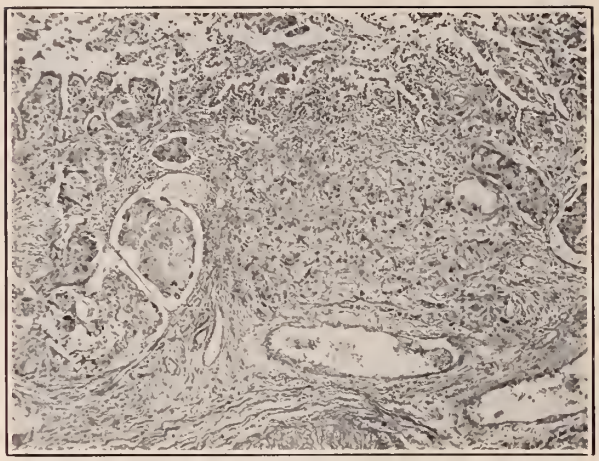


Fig. 1—Low power view, showing tumor thrombi in lymph vessels and infiltrating the lung parenchyma.

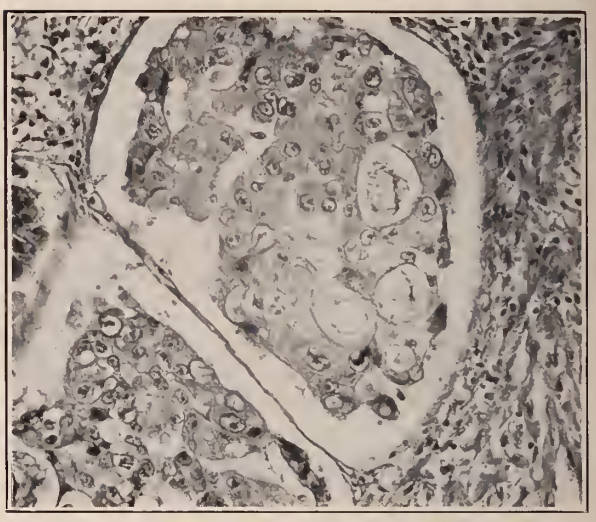


Fig. 2—Tumor thrombus in a lymph vessel.

had been previously removed, it would, of course, have had to be an extragenital tumor, which is uncommon but has been reported. Interestingly enough, the fluid obtained just before the patient died failed to show any tumor cells. Since considerable amounts of tumor were found on the pleural surfaces at the time of the autopsy, I am at a loss to explain this false negative result. Sputum examinations for tumor cells were made repeatedly but no tumor cells were found. I might add that other films of the chest were subsequently obtained which the radiologist thought showed questionable tumor infiltration.

At autopsy the significant findings were confined to the lungs and pleura. Both lungs were filled with a diffusely growing tumor. The tumor was growing in sheets, filling the alveoli in a manner quite similar to that of the exudate one sees in pneumonia. There were numerous tumor thrombi of the adenocarcinoma group in both the lymph vessels and the branches of the pulmonary vessels. In some places small amounts of mucus were found in pseudoacini. The site of origin was not determined with certainty, but I believe that the primary one lay in the right hilum, since the largest mass of tumor was found at this area. The tumor had extended to involve both pleural surfaces. The right pleural cavity was almost obliterated by tumor tissue, explaining the great difficulty with which fluid was obtained near the end of the patient's life. There was no evidence of carcinoma anywhere else in the body.

There have been some 70 to 80 cases similar to this reported in the literature. We have had two in this hospital. We did not do a postmortem examination on the second case, although we were able to confirm the diagnosis by Papanicolaou smears of the sputum and biopsy of the lung. About a third of these cases of lymphangitic carcinoma arise as a primary tumor of the lung. The remainder of them are metastatic in origin. The primary focus is often quite small and obscure and may not be found until after the patient's death. Attention is always directed to the lungs because of the tremendous dyspnea. The clinical pattern is quite characteristic, but I do not believe that one can differentiate between lymphangitic carcinomatosis, pulmonary adenomatosis, and some diffuse fibrous lesion such as Boeck's sarcoid or interstitial fibrosis.

Doctor Hefke: In radiology we must have microscopic help or wait for the postmortem in order to confirm our impressions. In this case there was not only effusion but also definite underlying lung pathology, displacement of the diaphragm upward, and involvement of the mediastinum. These manifestations could be explained either on the basis of tuberculosis or malignancy with effusion. This case is upsetting because we could not make a diagnosis until one or two months before death. We went months and months, not knowing what we were treating, using antibiotics, and never making a definite x-ray diagnosis. There were no lymph glands from which to obtain a biopsy. What then should one do? The best and easiest way would be to have a portion of rib removed and make a diagnosis surgically. It is up to the clinician to find out whether the lesion is inflammatory or malignant. If surgery is considered, take a rib out. It would avoid a great deal of difficulty and should be done early rather than wait until the last month.

Doctor Daniels (physician on the case): Doctor Belfus has made a careful analysis, a very logical discussion, and a correct conclusion. From the outset this patient had excellent medical attention at another hospital, where she was under the care of a good internist. At one point she was thought to have rheumatic fever because of the findings in the hands and ankles. She was also seen by another competent chest surgeon and we have his report of a bronchial stenosis which could not be interpreted properly. It probably was not pathological but functional. The pleural effusion on the right did not appear until after she was in this hospital. Pulmonary adenomatosis should be included in the differential diagnosis.

Originally this was our first consideration, and I think correctly, because she presented a picture which one does not see in the usual type of bronchiogenic carcinoma. It was characterized by a type of severe dyspnea, seen only in conditions such as berylliosis, emphysema, and a progressively downhill course with fever and death within a period of six months from the time that any serious attention was paid to her symptoms. The tremendous clubbing, including the wrists and ankles, suggested the condition of the joints in rheumatic fever. The sedimentation rate was high, a condition seen in carcinoma of the lung, but it does not mean that a low sedimentation rate could not be significant.

Doctor Birge: The tremendous dyspnea was due to the type of infiltrating carcinoma and the pleural effusion. It is the same as that seen in pulmonary adenomatosis, where the alveoli become lined by cells which do not allow the transmission of oxygen. In the microscopic sections of the lung one can see that there are tumor cells completely filling the majority of alveoli as well as occluding the smaller vessels and lymph vessels.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held from August 31 through September 4 at the Palmer House, Chicago, Illinois.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2, and 3. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

FIRST ANNUAL ESSAY AWARD

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to physical medicine and rehabilitation. Though open to anyone, the contest is primarily directed to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.

Rules and Regulations

1. Any subject of interest or pertaining to the field of physical medicine and rehabilitation may be submitted.
2. Manuscripts must be in the office of the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, not later than June 1, 1953.
3. Contributions will be accepted from medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.
4. The essay must not have been published previously.
5. The American Congress of Physical Medicine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the *Archives of Physical Medicine and Rehabilitation.*
6. Manuscripts must not exceed 5,000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.
7. The winner shall receive a gold medal properly engraved, a certificate of award, and an invitation to present the contribution at the 31st annual session.
8. The winner shall be determined by the Annual Awards Committee composed of four members of the American Congress of Physical Medicine and Rehabilitation.
9. All manuscripts will be returned as soon as possible after the name of the winner is announced.
10. The American Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the Annual Awards Committee, no contribution is acceptable. The Congress may also award certificates of merit to contributors whose essays may be considered second and third best submitted. Announcement of the winner will be made before August 1, 1953.
11. Officers and members of the American Congress and the American Society of Physical Medicine and Rehabilitation are not eligible for this award.

Comments from the Wisconsin Press

"Does Military Hoard Doctors?"

"The armed services may have many more doctors and dentists than they really need, Representative Davis (Rep., Wis.) suggests. He has asked Defense Secretary Charles E. Wilson to investigate. . .

"The military doctor-patient ratio does appear high . . . It was a good deal higher during World War II—one doctor in service for every 166 men . . . and has now been brought more nearly in line with current needs. . .

"It is hard to measure those needs in terms of civilian needs for doctors and dentists. Closer medical attention is given to military personnel than most civilians seek. Korean casualties and sick servicemen deserve the best care. There must be doctors ready for any bigger emergency, such as all-out Communist attack in Korea or elsewhere. Military doctors have many necessary duties not connected with ordinary civilian practice.

"Military physicians must be used to care properly for dependents of military personnel overseas and at some isolated military installations in this country. To a considerable extent, however, they are also used to treat such dependents where good civilian hospitals and doctors *are* readily available.

"If Secretary Wilson finds that the Pentagon isn't earnestly trying to eliminate actual waste of medical personnel, by all means a crackdown is in order."—MILWAUKEE JOURNAL, February 28, 1953.

* * *

"Stockpiling Medical Men?"

"Congressman Glenn Davis of Waukesha is rendering an important service by asking Secretary of Defense Charles E. Wilson to investigate the possibility that the armed services have been "stockpiling" doctors and dentists like critical material, with little immediate need for their services . . . Pointing out that census figures show one civilian physician for 785 people and one dentist per 2,000 people, but that the armed services have one medical officer for every 265 men, and a dental officer per 530 men, Davis wrote Secretary Wilson:

" 'Figures show a relatively high frequency of medical and dental officers at the present time, while physicians and dentists now on active duty complain to me they don't have enough work to do. And with a large number being called or recalled to duty at great personal hardship to them and to the communities they serve, I believe this is a matter worthy of very careful study by your office.

'On the surface, at least, it looks as though the armed services may be hoarding critical medical and dental personnel.' . . .

"If the Eisenhower administration is looking for fertile fields in which to eliminate waste, this would appear to be a good place to start."—WAUKESHA FREEMAN, February 21, 1953.

* * *

"Medical Schools Need Private Funds"

"All fields of higher education are facing serious financial problems, but in no area is the situation more critical than that confronting the nation's 79 medical schools. The schools are caught in a three-way dilemma: (1) pressure for more graduates, (2) necessity of maintaining high training standards and (3) insufficient funds. Their annual deficits—estimated at more than $10,000,000 for the current academic year—threaten their academic standards, teaching programs and the nation's supply of doctors—already short.

". . . Traditional sources . . . no longer provide sufficient revenue . . . The national fund for medical education warns that unless funds from other sources are swiftly forthcoming, the schools will have no choice but to accept federal subsidies—in the words of President Eisenhower, 'a perilous alternative' to private support. To avert this, the national fund—through its committee of American industry—has launched a nationwide . . . campaign to restore the medical schools to a sound financial basis and safeguard their independence.

". . . No segment of the national economy has a greater stake in medical education than industry . . . Moreover, industry is the only source of private support, other than the federal treasury, which can provide the necessary money quickly enough . . . The medical schools should be supported on the same plane as the Red Cross, the Community Chests and our other great public service agencies, as a national resource indispensable to our country's welfare."—WAUKESHA FREEMAN, March 12, 1953.

* * *

"Help for Deserving Students"

"The State Medical Society continues to play a part in helping deserving medical students and has made available $6,000 more out of its student loan fund. To be eligible for a loan, an applicant must be a resident of Wisconsin currently enrolled or about to enroll in a class A medical college. Preference is given to Wisconsin and Marquette University students. It is estimated that medical education now comes to a yearly cost of from $1,200 to $1,750."—MARINETTE EAGLE-STAR, March 6, 1953.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 APRIL 1953 Number 4

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Marton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officia)—Marshfield
W. S. Middleton (ex officia)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costella—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point

R. G. Arvesan—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'— 1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Medical Society License Plan Hit

Diverse Interests Join in Opposition

"Chiropractors and osteopaths teamed up with members of the State Board of Medical Examiners Wednesday to oppose the State Medical Society's proposals for modernization of the medical licensing laws.

"The unusual line-up occurred at a joint hearing of the Senate Public Welfare Committee and the Assembly Education and Public Welfare Committee.

"They heard arguments on three bills designed to modernize the licensing laws for doctors of medicine and osteopaths and to reorganize the State Board of Medical Examiners.

"Sen. Arthur Lenroot (R-Superior) introduced all three bills.

Provisions Listed

"Major provisions of the bills are:

"ONE. The board of examiners, or an agent approved by it, must investigate to determine that a medical or osteopathic college provides training substantially equivalent to that provided by the University of Wisconsin Medical School.

"TWO. Laws relating to quackery and unprofessional conduct are strengthened.

"THREE. The board of examiners shall have its headquarters in Madison. Heretofore the board offices have been located wherever the secretary lives.

"FOUR. The secretary of the board is to be the state health officer.

"FIVE. The board must meet at least four times a year to examine and license doctors.

"Atty. R. B. L. Murphy, Madison, representing the medical society, contended that the board of examiners is not always in a position to investigate schools in other states or foreign countries and therefore must rely on agents appointed for the purpose.

Denies Need for New Law

"Dr. A. G. Koehler, Oshkosh, secretary of the Board of Medical Examiners, argued that no new law is needed since the board simply accepts the word of the American Medical Association or the American Osteopathic Association as to which schools are approved.

"Atty. Oscar Toebaas, Madison, representing the Wisconsin Osteopathic Association, said that per-

mitting an 'agent' to make investigations was a 'very dangerous thing' since the agent may be 'prejudiced against osteopaths.'

"Nomadic Life"

"C. H. Crownhart, Madison, secretary of the medical society, said the board leads a 'nomadic life' by virtue of the fact that its offices change every time a new secretary is elected. He argued that persons trying to contact the board expected to find it in Madison.

"He contended that the board secretaryship was a full-time job, 'not a hobby, as it seems to be now.' He said the state health officer is a full-time administrator with competent staff and office equipment to handle the routines of the job.

"Dr. E. C. Murphy, Eau Claire, osteopathic member of the board of examiners, countered with the charge that 'Madison is the most difficult place in the state to get to.' He said the state health officer wouldn't understand the problems of the practicing physician, and the fact that he already is responsible for administering 38 departments would 'create even greater delays.' "—From the WISCONSIN STATE JOURNAL, March 19, 1953.

There Is a Use

The following is presented in reply to the editorial in the February 1953 issue of *The Wisconsin Medical Journal*, "What's the Use?" It is the opinion of myself and other staff members of the Bureau for Handicapped Children that some of the conclusions made by the editor are probably because of lack of information about the Wisconsin Hearing Conservation Program. We certainly agree that the family doctor should be an integral part of our program, and would welcome suggestions as to how we can bring him more into the program. This was one of our main reasons for making the study and publishing the results in the *Journal*.

The basic philosophy in the development of the Hearing Conservation Program has been to make it a community program centered around the family doctor. Programs are held only with the approval of the local medical society. Local physicians are invited to attend the otologic screening clinics. All reports of the recommendations made by the otologist and the record of the child's hearing examination are sent to the child's family physician. The suggested medical and surgical procedures that will improve or correct the impaired hearing condition are left to the decision of the family physician. He is the key to the success of the program! Perhaps the word "success" needs enlarging. To an otologist, the local county hearing conservation program which is climaxed by the otologic screening clinic is a success if it brings to light one or two cases of chronic discharging ears for which treatment can be given, the ear infection cleared up, and perhaps a future brain abscess avoided or even a life saved; if it reveals a few cases of impacted cerumen, for which "miraculous" cures of the child's impaired hearing can be given in a matter of minutes; if it gives the doctor an opportunity to discuss with a child's family the importance of having a tonsillectomy and adenoidectomy—these are only a few! The opportunity is great—an opportunity to educate communities that something can be done for their children with impaired hearing.

The question of the "vast amount of money" was brought up. May we merely give you the facts and let you draw your own conclusions. In order to screen those children who have a hearing impairment, each year approximately 125,000 children in Wisconsin are given individual audiometric tests. Approximately 2,000 of these are seen each year in the otologic screening clinics. In order to examine this large number each year, a great deal is done by local community people. Two of the men on the staff of the Bureau for Handicapped Children, our Hearing Consultants, assist communities with this program. Otologists who give a full day's service at the clinics and examine at least 40 children receive $50 a day. Secretarial and administrative services are provided through the state office. As far as state funds are concerned, the Hearing Conservation Program costs 20 cents a child. This includes the salaries and traveling expenses of the two Hearing Consultants.

From the study made it was found that "less than one half" (43 and 44 per cent) of the recommendations made were carried out. In a private practice, how many of the physician's recommendations are carried out by his private patient? Is it 50 per cent?

In conclusion, may it be re-emphasized that in all public health programs there is always an opportunity for improvement. We are constantly striving to improve our services. We believe there *is* a "use"!—BUREAU FOR HANDICAPPED CHILDREN, by Maxine Bennett, M. D., Medical Director.

SPECIALTY GROUPS AT ANNUAL MEETING

Several state specialty groups will hold scientific meetings as a part of the Annual Meeting. On Tuesday, October 6, the Wisconsin Society of Anesthesiologists and the Wisconsin Orthopedic Society will use portions of the scientific program for their specialty meetings; on Wednesday, October 7, the same arrangements have been made for the Wisconsin Society of Obstetrics and Gynecology and the Wisconsin Society of Pathologists; on Thursday, October 8, the Wisconsin Pediatric Society and the Wisconsin Society of Radiologists will hold similar meetings. If you are a member of one of these specialty groups, be sure you plan to attend on the day when your affiliate society will meet.

. . . . THE PRESIDENT'S PAGE . . . .

BROADENING prepaid health plans to include more of the population and increasing the scope of the insurance to cover catastrophic illness was recommended to and approved by the House of Delegates of your State Medical Society last fall. One of the goals in the AMA platform for 1953 is the establishment of catastrophic insurance methods to fill a need in the voluntary insurance field. The Magnuson Commission report has emphasized the desirability of expanding the insurance field into catastrophic coverage.

At present a total of 645,000 persons are covered for medical and surgical benefits under Wisconsin Blue Shield plans, 878,000 persons have Blue Cross protection for hospital expense, and probably about 250,000 more have both medical and hospital coverage by private insurance companies cooperating with the State Medical Society. Though this is an impressive record, we should not be lulled into thinking that there is no further need for extension of services. One area that requires attention is in relation to the prolonged and expensive illness, where benefits have not been adequate. Another concerns people in rural communities and sparsely populated sections, farmers, the self-employed, single or with families, and those in small groups, who have been able to participate only under an individual contract. Because of the higher cost of selling and servicing individual contracts, they have not been sufficiently popular with these groups.

It is significant to note that at a meeting on March 27 and 28 the Commission on Prepaid Plans of the State Medical Society directed that the WPS staff proceed at once with the development of a catastrophic insurance policy providing protection up to $5,000 per person covered. Benefits would be available after the basic benefits of Blue Shield and Blue Cross, or other insurance benefits, had been exhausted. Efforts would be made to integrate Blue Cross in the program, dovetailing the coverages of the two agencies to achieve maximum protection for the people. This program would answer the needs of those suffering from cancer, heart disease, and other chronic illnesses as well as those who have had unusually severe accidents.

The Commission also approved a Community Enrollment Program, which would enable individuals and families who heretofore could get coverage only on a higher-cost single-contract basis to join Blue Shield and Blue Cross on a group basis. It is proposed, for example, that a community enrollment be conducted in Green County. All people in that county not now enrolled in the plans may enroll at that time as members of a Community Group and receive the more liberal group benefits. This would be the answer to the problem of the towns, villages, and rural areas, and the farmer and the self-employed.

These programs can become activated only after final approval by the Commission and the Council, but it is significant that your Society is making a sincere effort to bring medical care to the people of Wisconsin, whenever and wherever the real need exists.

J. C. Griffith M.D.

OFFICIAL CALL FOR

Scientific Exhibits

★

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6–7–8

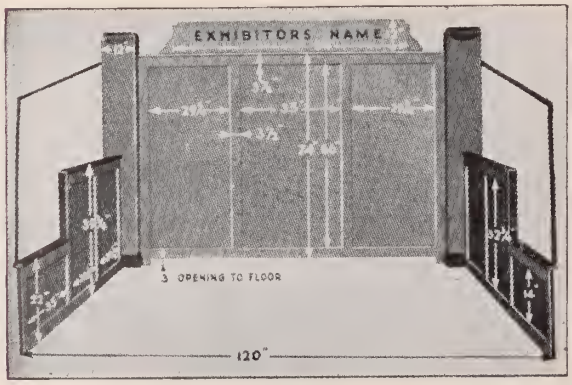
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1953 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1953 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of gray wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to S. A. Morton, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1953 ANNUAL MEETING MILWAUKEE OCTOBER 6-7-8

Fill Out and Mail to:

S. A. MORTON, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

---

1. Title of exhibit: _____

2. Description of exhibit (attach 200 word description to this blank): _____

3. The standard booth is 10′ wide and 9′ deep. _____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be used? If so will you furnish them? _____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

EXAMINATION DATES SET BY INTERNATIONAL COLLEGE OF SURGEONS

Qualifying examinations for Fellowship in the U. S. Section of the International College of Surgeons will be held on the following dates in 1953: Feb. 2 and 3, May 4 and 5, Aug. 10 and 11, and Nov. 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine and the Cook County Hospital. Applicants are requested to address communications as follows: Harry A. Oberhelman, M. D., Secy., Qualification and Examination Council, 1516 Lake Shore Dr., Chicago 10, Ill.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Catastrophic Insurance

One of the significant actions of the Commission on Prepaid Plans of the State Medical Society at its March 24–25 meeting was an instruction to "proceed at once" in the development of a "catastrophic insurance" policy for Blue Shield.

The Commission envisions a policy providing protection probably up to $5,000 per person covered. Benefits will be available only after the basic benefits of Blue Shield and Blue Cross, or other insurance benefits, have been exhausted.

Benefits will be offered on what amounts to a co-insurance basis. For example, it might be provided that Blue Shield will pay $750 of each $1,000 of surgical and medical expenses but the total that might be paid by Blue Shield would not exceed $5,000.

The program is to be developed in cooperation with Blue Cross in an endeavor to integrate Blue Cross in the program, dovetail coverage to the extent possible, and to achieve uniformity of contract and administration.

A "catastrophic insurance" program will become operative only after approval by the Council of the State Medical Society and specific approval by the Commission on Prepaid Plans.

The action is evidence of the medical profession's responsiveness to the needs of the people in light of modern medical developments. Through this device, the profession hopes to be of further help to provident people who seek adequate means of prepaying the costs of illness.

Community Enrollment

Blue Shield will soon be available to many Wisconsin people on a "community enrollment" basis as the result of action by the Commission on Prepaid Plans on March 25. Both Blue Shield and Blue Cross will be offered on this basis.

Community enrollment coverage is designed to provide quality surgical-medical protection to persons who do not qualify for group insurance. Enrollment under this plan is scheduled to begin, in a limited area, during the summer.

Community enrollment subscribers will be offered conversion contract benefits, including maternity, at the conversion rate. Subscribers will be offered Blue Cross comprehensive coverage and the choice of "A" or "B" benefits under the "5 element" (surgical, medical, anesthesia, x-ray, and maternity benefits) program of Wisconsin Physicians Service. Coverage will be available for families and individuals up to age 70.

Enrollment will be conducted during a limited period of time for each community. The area encompassed by a community enrollment program will most likely be limited to a county, at least during the initial stages.

Persons who have certain chronic, pre-existing conditions will not be eligible for coverage. All persons who enroll will be subject to waiting periods of nine months for maternity, tonsillectomies and adenoidectomies, and certain other pre-existing conditions.

The entire community enrollment program is being worked out jointly by Blue Shield and Blue Cross and full details will be available soon.

Notes on Benefits

Poison Ivy—Treatment of poison ivy is not paid as a surgical procedure comparable to a burn, but if the patient is hospitalized, medical care benefits will be provided.

Multiple Thoracenteses — Each thoracentesis is considered an individual procedure and a benefit is available for each thoracentesis at $15 under the "A" schedule and $10 under the "B" schedule.

Inhibition of Excess Parasympathetic Stimuli in Peptic Ulcer with Banthīne®

Medical literature now contains more than 200 references to the beneficial role of Banthine Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of the drug in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is indeed a desired approach in ulcer management.

Treatment is individualized to the patient's needs. One or two tablets (50 to 100 mg.) is administered every six hours, around the clock, in conjunction with appropriate diet control and antacid medication as indicated.

Banthine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle: Research in the Service of Medicine.

Ulcer Facies Composite

COMMITTEE *Concentrates*

INTERIM COMMITTEE
FEBRUARY 27

MDs present: J. C. Griffith (chairman), H. Kent Tenney, R. G. Arveson, J. M. Bell, J. C. Fox, R. E. Galasinski.

After further discussion of the study on group malpractice insurance, the committee favors recommending to the Council that the Grievance Committee be asked to conduct a detailed study, with a report back to the Council, and that it be provided with a budget for this purpose. The committee recommended that the Society continue its sponsorship of the Governor's Conference on Children and Youth . . .recommended the appointment of Dr. P. C. Dietz as the physician member of the coordinating committee created in connection with the Code of Necropsy . . . recommended increasing from 5 to 7 the number of members of the Military Medical Service Committee, to provide greater geographic representation . . . recommended Council approval of the report of the Committee on Blood Banks and Blood Procurement, which calls for close cooperation of the medical profession with the State Health Officer in connection with the donation of blood and the allotment of gamma globulin.

ANNUAL MEETING OF THE COUNCIL
FEBRUARY 28–MARCH 1

MDs present: R. G. Arveson (chairman), T. C. Hemmingsen, N. A. Hill, E. M. Dessloch, A. H. Heidner, J. C. Fox, J. M. Bell, E. E. Kidder, V. E. Ekblad, R. E. Galasinski, E. L. Bernhart, W. T. Casper, N. J. Wegmann, C. E. Zellmer, J. C. Griffith, H. Kent Tenney, Gunnar Gundersen, C. D. Neidhold, J. W. Fons, G. E. Forkin, S. E. Gavin, F. L. Weston, W. D. Stovall.

At its annual meeting action was taken on the budget and officers were elected: R. G. Arveson, chairman of the Council; F. L. Weston, treasurer; C. H. Crownhart, secretary . . . J. M. Sullivan re-elected editorial director of the *Journal*, J. M. Bell re-elected to Interim Committee . . . reports of Interim Committee and Commission on Prepaid Plans approved . . . approved resolution for adoption by House of Delegates establishing a Section on Medical History for the purpose of supervising and directing programs and projects in the field of medical history . . . reviewed report of House Planning Committee designating Allen J. Strang of Madison as architect and setting up machinery to develop building program.

COMMITTEE ON MILITARY MEDICAL SERVICE
MARCH 9

MDs present: F. L. Weston (chairman), M. H. Steen, O. G. Moland, M. J. Musser.

The committee considered individual Selective Service cases and made recommendations. The committee also considered directives which announced that physicians in Priority III up to the age of 38 are now eligible for call to service. Selective Service has requested 27 physicians from Wisconsin for April.

COMMITTEE ON PUBLIC POLICY
MARCH 18

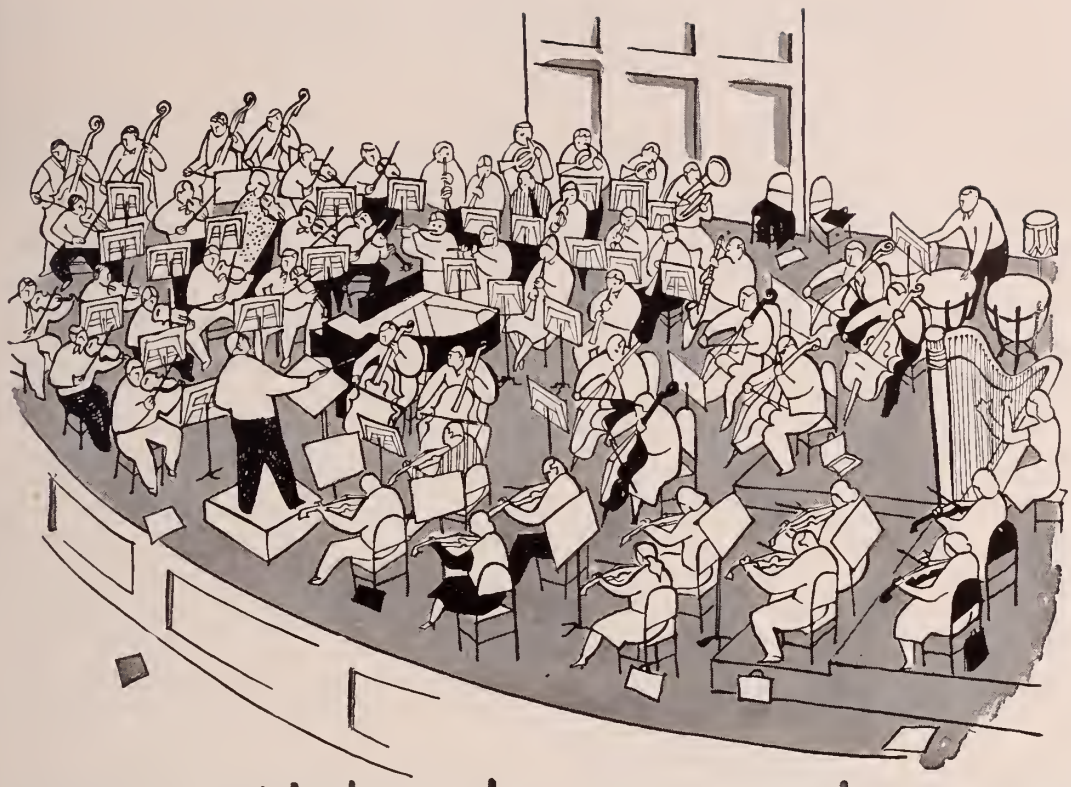
MDs present: J. M. Sullivan (chairman), S. E. Gavin, J. K. Curtis, J. M. Schroder, J. A. Enright, H. Kent Tenney, J. C. Griffith, V. E. Ekblad, R. E. Garrison, C. N. Neupert.

In addition to attending the joint hearing on Bills 160, 161, and 162, S., the major portion of the State Medical Society legislative proposals, the committee had a business meeting and considered the effect on the medical profession and public health of over 30 bills currently in the legislature. The committee told the staff and legislative counsel its position on such subjects as the cooking of garbage for swine, fluoridation, dangerous drugs, codification of children's laws, commitment of state-county cases to Wisconsin General and Wisconsin Orthopedic Hospitals, labeling of seeds treated for fungicides, examination for food handlers, approval of hospitals, and county sanatoria appropriations.

COUNCIL ON SCIENTIFIC WORK
MARCH 29

MDs present: T. O. Nuzum (chairman), J. W. Gale, S. A. Morton, P. A. Midelfart, M. G. Rice, R. S. Baldwin, J. S. Hirschboeck, W. S. Middleton.

Final plans made for program of 1953 Annual Meeting. Reports on scientific exhibits and demonstrations presented . . . policies on "sponsored" speakers recommended. Studied progress of postgraduate teaching programs. Accepted suggestion that in 1954 programs be concentrated in late spring months . . . approved proposed program of Wisconsin Division of Cancer Society to present a series of cancer programs



they could stage their own symphony

. . . all the patients who represent the 44 uses for short-acting

NEMBUTAL®

EVER WONDER WHY one drug should survive 23 years of clinical experience (when a lifetime for many is only about five)? Why it should account for 598 published reports? Or more than 44 clinical uses?

Short-acting NEMBUTAL (Pentobarbital, Abbott) is the drug. The reasons why?

1. Short-acting NEMBUTAL can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.
2. The dosage required is small—only about half that of many other barbiturates.
3. There's less drug to be inactivated, shorter duration of effect, wide margin of safety and usually no morning-after hangover.
4. In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.

How many of short-acting NEMBUTAL's 44 uses have *you* tried? You'll find details on all in the booklet, "44 Clinical Uses for NEMBUTAL." Write Abbott Laboratories, North Chicago, Illinois. Abbott

1-126

next November. Subjects to be covered: oral cancer, cancer of the lung, uterine cancer, cytologic examinations. Plan to have dentists meet with doctors on at least a portion of the program. Council studied responses of county societies and hospitals to suggestion that tape recordings be developed to form library for local groups . . . authorized further development with help of two medical school faculties.

RELATED ACTIVITIES

Motor Vehicle Department setting up an advisory committee, and SMS being asked to serve . . . Dr. John Doolittle, Madison, to represent the Society. Big turnout at Industrial Health Clinic in Milwaukee on March 12 . . . program on "Rehabilitation" well received . . . some 300 MDs, nurses, and plant representatives present . . . joint program by Medical Society of Milwaukee County, Industrial Hygiene Unit of State Board of Health, and SMS. Medical problems of migrant workers again being aired . . . this time sponsoring agency is Wisconsin Welfare Council, and SMS sitting in on special section discussing health matters.

Assistant Secretary attended National Health Council meeting in New York on March 17–19, where President's Commission on Health of the Nation Report was cussed and discussed. A.M.A. organized all MDs attending, so that all five discussion groups were made fully aware of MDs' views on the recommendations of the report. Hottest section on that of financing, with side arguments on the Commission's significant failure to give a pat on the back to voluntary plans and obvious approval of suggestion that the compulsory approach was still an open question, in spite of the November elections.

Postgrad teaching programs at Beaver Dam, Marshfield, and Neenah on March 24, 25, and 26 an unqualified success . . .good attendance, expressions of great interest, and tons of questions directed to the speakers. At Neenah over 100 MDs and wives attended evening session, with President-elect Tenney speaking on "Emotional Problems of the Growing Child." SMS represented on program of senior medical students, arranged by John Brown, M. D., director of student health, U. of W. Medical School, and held at various plants in Madison . . . presented an opportunity of acquainting the potential members with role of SMS in various industrial health programs.

REMINDER: *On Regional Teaching Programs*

If you have not already done so, sign up for the regional meetings listed below which are nearest your home. Registration $6.00, including dinner. (For the June clinics in northern Wisconsin, where wives will attend, joint dinner reservations are $9.00.)

MAY

WEDNESDAY, MAY 13: Delavan (Lake Lawn Resort)

THURSDAY, MAY 14: Sheboygan (Pine Hills Country Club)

FRIDAY, MAY 15: Green Bay (Elks Club)

Joseph W. Gale, M.D., Madison, Moderator
(Program from 2:00–5:00 p.m.)

Metabolic Problems in General Practice: E. S. Gordon, M.D., Associate Professor of Medicine, University of Wisconsin Medical School, Madison

Recent Advances in Obstetric Practice: John Parks, M.D., Professor and Head of Department of Obstetrics and Gynecology, George Washington University, Washington, D. C.

The Problem of Chronic Cystic Mastitis with Special Reference to Its Relation to Carcinoma: Robert Elman, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis

The Convulsive Disorders in Childhood: M. G. Peterman, M.D., Head of Department of Pediatrics, Milwaukee County Hospital, Milwaukee

JUNE

WEDNESDAY, JUNE 24: Hayward (Radio Joe's Inn)

THURSDAY, JUNE 25: Minocqua (Minocqua Country Club)

PHYSICIANS' WIVES ARE INVITED TO ATTEND THESE CLINICS. SPECIAL ENTERTAINMENT WILL BE PROVIDED.

E. H. Jorris, M.D., Madison, Moderator
(Program from 2:00–5:00 p.m.)

Some Newer Concepts Concerning the Prevention and Treatment of the Late Toxemias in Pregnancy: John W. Harris, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison

Recent Advances in Pediatrics of Importance in General Practice: Charles May, M.D., Professor and Head of the Department of Pediatrics, State University of Iowa College of Medicine, Iowa City

The Clinical Significance of Vascular Changes in the Skin: William Bean, M.D., Professor and Chairman of the Department of Internal Medicine, State University of Iowa College of Medicine, Iowa City

Society Proceedings

Dodge

Dodge County newspapermen, law enforcement officers, and the county coroner were guests of the Dodge County Medical Society at a dinner meeting February 26 at the Waupun Memorial Hospital. Arranged by the public relations committee of the society, the meeting was called to discuss a uniform code of procedure in the newspaper-physician relationship in accident cases. Leader of the discussion was Byron Ostby, field secretary of the State Medical Society.

Fond du Lac

Dr. Hans W. Hefke, chief of radiology at Milwaukee Hospital and Milwaukee Children's Hospital, spoke on "Problems of Pediatric Radiology" at the February 26 dinner meeting of the Fond du Lac County Medical Society at the Elk's Club. *Dr. Howard Mauthe,* chief of radiology at St. Agnes Hospital in Fond du Lac, was program chairman and, with *Drs. Clifton R. Peterson* and *E. H. Pawsat,* formed a panel to lead the discussion on Doctor Hefke's lecture.

During the business session, Doctor Mauthe gave a detailed report of the relationship of the Fond du Lac County Health Society and the Wisconsin Anti-Tuberculosis Association. The society voted to endorse the radio programs on heart disease sponsored by the Wisconsin Heart Association and to discuss possible arrangements for such a series on Station KFIZ.

Green Lake–Waushara

E. F. CUMMINGS

At the February 26 meeting of the Green Lake–Waushara County Medical Society, held at the Hotel Whiting in Berlin, *Dr. Earl F. Cummings* of Oshkosh shared with the members the practical information he has gleaned from meetings of the Urological Society during the past five years.

During the business session, the society voted to sanction the proposal of the Waushara County Nurses Association that prenatal classes be instituted, and agreed to petition the Wisconsin Heart Association to hold a rheumatic fever clinic at the Berlin Hospital in June 1953.

Kenosha

"The Differential Diagnosis and Treatment of Peripheral Venous Clotting" was the title of a speech by Dr. Francis W. Young, head of the Cook County Graduate School of Medicine in Chicago, at the March 5 meeting of the Kenosha County Medical Society.

Another guest of the society at this meeting was *Dr. Elmer Bertolaet,* new director of the Kenosha City Health Department. At his suggestion, a liaison committee was appointed by the president to work with the health department on a continuous basis. The society also discussed problems arising from immunization and well-child clinics.

Manitowoc

In the temporary absence of *Dr. W. C. Randolph* for military service, *Dr. Daniel M. Pick* has been appointed secretary–treasurer of the Manitowoc County Medical Society. Doctor Pick's appointment took effect March 5.

Outagamie

P. F. DOEGE

About 30 members of the Outagamie County Medical Society heard *Dr. Paul F. Doege* of Marshfield speak on "Management of Cancer of the Large Bowel" at the February 19 meeting of the society. The meeting was held at the Elk's Club in Appleton.

Price–Taylor

Dr. Arthur DeBoer of Children's Memorial Hospital in Chicago presented a paper on "Surgery of Children" at the February 28 meeting of the Price-Taylor County Medical Society. The meeting was held at the Leahy Clinic in Park Falls.

Discussants were *Drs. J. D. Leahy* and *J. J. Leahy,* Park Falls; *W. W. Meyer,* Medford; and *J. L. Rens,* Phillips.

Racine

"Ophthalmology in General Practice" was the title of a speech by *Dr. John B. Hitz* of Milwaukee at the February 19 meeting of the Racine County Medical Society. The meeting was held at the Racine Country Club. Doctor Hitz is a member of the department of ophthalmology of Marquette University School of Medicine.

Sheboygan

New officers of the Sheboygan County Medical Society for 1953 include the following physicians:

President—*J. W. McRoberts*
Vice President—*Bernard S. Marsho*
Secretary–Treasurer—*Henry J. Winsauer*

Trempealeau–Jackson–Buffalo

The regular meeting of the Trempealeau–Jackson-Buffalo County Medical Society was held February 10 at the Club Midway, just east of Independence.

Guest speaker was Dr. Charles W. Rogers, a pediatrician from Winona, Minn.

Winnebago

A talk on Korea by *Dr. Anthony R. Curreri* of Madison was the feature of the February 5 meeting of the Winnebago County Medical Society, held in the Hotel Athearn in Oshkosh. Doctor Curreri supplemented his talk with films taken during his recent trip to Korea.

Wood

Dr. James S. Vedder, Marshfield pediatrician, was elected president of the Wood County Medical Society at its regular meeting held February 28 at the Hotel Charles in Marshfield. Doctor Vedder succeeds *Dr. Elmer Debus* of Wisconsin Rapids.

Re-elected as secretary-treasurer of the society was *Dr. R. W. Mason*, Marshfield orthopedic surgeon. The new vice president is *Dr. Harold G. Pomainville*, Wisconsin Rapids.

Papers read during the meeting were "Paravertebral Lumbar Sympathetic Block," by *Dr. John L. Burns, Jr.*, of Marshfield and "Ophthalmological Aspects of General Practice," by *Dr. E. G. Barnet*, Wisconsin Rapids.

Wisconsin Academy of General Practice Manitowoc Chapter

"The family physician stands as the bulwark of free enterprise," declared *Dr. Jerome Fons*, president of the Wisconsin Academy of General Practice, at a meeting February 26 of the Manitowoc Chapter of the WAGP. Speaking to a group composed of members of the Manitowoc Chapter, members of chapters in Neenah, Menasha, Sheboygan, Appleton, and Green Bay, and members of the Manitowoc County Medical Society, Doctor Fons stated that in treating 85 per cent of the nation's ills the family physician "brings to his patients, under the free enterprise system, the many marvels of medical research and knowledge." Doctor Fons spoke of the important position that family doctors play in insuring adequate medical care for the public from birth to death.

In explaining the work of the WAGP, Doctor Fons said that the Academy exerts "a continual check on its membership to determine whether every member complies with the standards of general practice." Members who do not live up to this strict set of standards are dismissed by the national organization, the American Academy of General Practice.

Wisconsin Surgical Club

Seventeen surgeons, members and guests of the Wisconsin Surgical Club, visited hospitals in Washington, D. C., Baltimore, Md., and Philadelphia, Pa., during their annual tour from February 9 through February 14.

In Washington they were guests of Dr. Brian Blades at the George Washington University Hospital and Brig. Gen. Sam Seeley at Walter Reed Army Hospital. From Washington the group traveled to Baltimore to visit the University of Maryland Hospital with Dr. C. Reid Edwards as their guide and the Johns Hopkins Hospital, where their host was Dr. Alfred Blalock.

During their stay in Philadelphia they were entertained by Dr. I. S. Ravdin at the University of Pennsylvania Hospital; Dr. W. E. Burnett at the Temple University Hospital; and Dr. John Gibbon, Jr. and his associates at the Jefferson Medical College of Philadelphia.

Guests of the Club on this year's tour were *Dr. Frank D. Weeks*, Ashland; *Dr. M. G. Rice*, Stevens Point; *Dr. Edmund W. Schacht*, Racine; *Dr. Louis D. Graber*, Oshkosh; *Dr. J. W. McRoberts*, Sheboygan; and *Dr. Norman O. Becker*, Fond du Lac.

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
(The Pioneer Post-Graduate Medical Institution in America, Organized 1881)

Urology

A combined full-time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection; attendance at departmental and general conferences.

DERMATOLOGY AND SYPHILOLOGY

A three year course fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also five-day seminars in Dermatopathology, for specialists and for general practitioners.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

Upjohn

less-antigenic penicillin:

Cer-O-Cillin

Trademark Reg. U. S. Pat. Off.

POTASSIUM

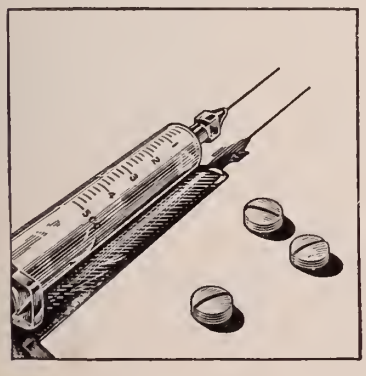
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Available as:

Sterile vials containing 200,000 units Crystalline Penicillin O Potassium

Bottles of 12 buffered tablets, each containing 100,000 units Crystalline Penicillin O Potassium

The Upjohn Company, Kalamazoo, Michigan



News Items and Personals

Coloradan Trades Denmark for Green Bay

After three years of practice in Denmark, *Dr. C. J. Hipps* has set up an office for the practice of general medicine, obstetrics, and surgery in Green Bay, where he will be associated with *Drs. I. E. Levitas* and *A. J. McCarey*.

A native of Colorado and a graduate of the University of Colorado School of Medicine, Doctor Hipps served his internship at the U. S. Naval Hospital in San Diego. After two years in naval service, he spent a three-year residency in general surgery at the Veterans Administration Hospital at Fort Logan, Colo., before going to Denmark.

Doctor Hipps is a member of the Brown–Kewaunee–Door County Medical Society and the American Medical Association and is a junior candidate in the American College of Surgeons.

Dr. R. C. Cantwell Talks on Heart Disease

Dr. Roger C. Cantwell of Shawano, a member of the board of directors of the Wisconsin Heart Association, discussed the heart and heart disease at a meeting of the Mayflower Women's Club in Antigo on March 5. Doctor Cantwell's talk was one of many similar talks sponsored by the Wisconsin Heart Association in its program to educate the public in the recognition, care, and prevention of heart disease.

Dr. William T. Russell Resumes Practice

After two years as a captain in the armed forces, *Dr. William T. Russell* has returned to Sun Prairie to resume his medical practice with *Drs. J. F. Behrend* and *L. W. Peterson*. The doctor is a graduate of the University of Wisconsin Medical School and had practiced in Waterloo from 1947 to 1949.

Doctor Boren Addresses PTA

Rheumatic fever was the topic of a talk by *Dr. J. W. Boren, Jr.* of Marinette at a meeting of the Beaver PTA Tuesday, March 10. A round-table discussion, during which Doctor Boren answered the questions of the audience, followed the lecture.

Doctor Custer Addresses Graduate Nurses

"Public Relations" was the title of a talk by *Dr. G. S. Custer* at a meeting of the Alumnae Association of St. Joseph's School of Nursing in Marshfield February 12. In his discussion of the relationships, responsibilities, and necessary qualifications of employers and employees, Doctor Custer stressed the need for flexibility and self-understanding.

Doctor Custer is a member of the staff at the Marshfield Clinic.

Cannery Conference Hears Doctor Hoyer

A talk on "Parathion Poisoning" by *Dr. E. C. Hoyer* was part of the 1953 Wisconsin Cannery Fieldmen's Conference held in Madison January 28 and 29. The conference was sponsored by the University of Wisconsin College of Agriculture in cooperation with the Wisconsin Canners Association.

Doctor Hoyer is associated with the Hoyer Clinic at Beaver Dam.

Kiwanians Honor Doctor Newell

A gold watch with the inscription *"Frank F. Newell, M. D.*, in appreciation of 52 years of loyal medical service" was presented to the 73 year old Burlington physician at a dinner given in his honor by the Burlington Kiwanis Club March 9. Over 60 persons, including Doctor Newell's nephew Dr. George Newell, a Racine dentist, attended the special honoring ceremony.

Speaker of the evening was *Dr. J. F. Bennett*, Burlington physician and surgeon who himself was observing his thirty-fifth year as a doctor. In his account of Doctor Newell's family and professional history, Doctor Bennett pointed out that Doctor Newell was the son, grandson, and great-grandson of physicians and had started his medical practice in association with his father, the late Dr. George E. Newell, in Burlington.

Born in Waterford on December 11, 1879, Doctor Frank received his degree in medicine from the Northwestern University Medical School in 1900, when he was only 20 years old. After spending a year in Burlington he took a postgraduate course in Chicago and on his return to Burlington joined his father, with whom he worked until he moved to Waukesha in 1902. Six months later he returned to Chicago, where he was associated with Dr. S. C. Plummer, then chief surgeon of the Rock Island Railroad Company. During his stay in Chicago he was demonstrator of anatomy and operative surgery at Northwestern. On returning to Burlington to settle, he set up practice with his father and his brother, the late Dr. G. Warren Newell.

Throughout his career Doctor Newell has kept abreast of new developments in his profession by research and study and through his membership in the Racine County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. He has also attended surgical clinics in most of the major cities of this country and Europe, including London, Belfast, Dublin, Edinburgh, Glasgow, Copenhagen, Oslo, Stockholm, Berlin, Zurich, Bern, Lausanne, and Paris. In London he was received by the Duke of York, in Ireland by the Governor General, and in Washington by President Harding.

SHOREWOOD
HOSPITAL • SANITARIUM
2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

In closing his testimonial speech, Doctor Bennett said "If Frank Newell had received payment for 65 per cent of his services for the past 50 years, he would be a rich man."

Dr. F. W. Reichardt of Stevens Point Passes Orthopedic Boards

F. W. REICHARDT

Word has been received that *Dr. F. W. Reichardt*, Stevens Point, has successfully passed the second part of the two-part examinations of the American Board of Orthopedic Surgeons. This achievement is the result of four years of intensive study in orthopedics.

Orthopedic specialist at the Rice Clinic since January 1952, Doctor Reichardt practiced medicine in Stevens Point in 1947 and 1948 and spent the following three years as resident physician in orthopedics at Wisconsin General Hospital in Madison.

Dr. Margaret Hatfield Heads District 2

Dr. Margaret E. Hatfield has been appointed medical director of District 2 of the State Board of Health to succeed *Dr. Elmer O. Bertolaet*, who resigned the state post February 1 to head the Kenosha City Health Department. With headquarters in Elkhorn, Doctor Hatfield will supervise the state health services of Waukesha, Rock, Jefferson, Walworth, Racine, Kenosha, and Milwaukee counties.

A native of Madison and a 1927 graduate of the University of Wisconsin Medical School, Doctor Hatfield obtained a master's degree in public health in 1948 at the University of Michigan and in 1950 was certified as a specialist in public health by the American Board of Preventive Medicine and Public Health.

Her experience in public health is wide. In February 1938 she left private practice in Janesville to become county health physician of the newly created Rock County health unit, a post she held until 1947. Before joining the staff of *Dr. E. R. Krumbiegel*, Commissioner of the Milwaukee City Health Department, she served as district health officer for the State Board of Health at Ashland. As supervisor of activities in the northwest section of Milwaukee under Doctor Krumbiegel, she became the first woman to hold a high administrative office in the Milwaukee City Health Department.

LIQUID PLASMA

U. S. LICENSE 187

Half pint units of liquid plasma available.
(Recipient set not included.)

Save by ordering directly from:

JUNIOR LEAGUE BLOOD CENTER

763 No. 18th St. Milwaukee 3, Wis.

In very special cases
A very superior Brandy

Specify 84 PROOF

★ ★ ★

HENNESSY

THE WORLD'S PREFERRED
COGNAC BRANDY

For a beautifully illustrated book on the story of Hennessy, write—

Schieffelin & Co., Dept. HT, 30 Cooper Square, N.Y. 54

Dr. Elizabeth Baldwin Named Marshfield Health Officer

Dr. Elizabeth Baldwin, practicing physician in Marshfield, has been named city health officer to fill the vacancy caused by the resignation of *Dr. F. A. Boeckman.* Doctor Baldwin will serve until May 1, 1953, when Doctor Boeckman's term expires.

A graduate of the University of Wisconsin Medical School, Doctor Baldwin served her internship at St. Joseph's Hospital in Marshfield, where she had worked as a senior medical student. She opened a private office for the practice of medicine and surgery in September 1949.

Krohn Clinic Adds Two New Members

Dr. Robert Krohn, chief of staff of the Krohn Clinic in Black River Falls, has announced the appointment of two new staff members, *Dr. Ann Cinelis* of Sheboygan and *Dr. Donald R. Peterson* of Independence.

The first woman doctor to practice in Jackson County, Doctor Cinelis had a private practice in Sheboygan before she accepted her present position in Black River Falls. She is a 1948 graduate of the University of Wisconsin Medical School and a registered nurse with seven years' experience.

Doctor Peterson, a graduate of the Marquette University School of Medicine, worked for several years in Independence with his father, *Dr. C. F. Peterson.* In July 1951 he established a practice in Strum and was affiliated with the Sacred Heart and the Luther hospitals in Eau Claire.

Dr. R. E. Henning New AAL Medical Director

Dr. R. E. Henning, practicing physician in Neenah since 1948, has been appointed medical director of the Aid Association for Lutherans in Appleton. He replaces *Dr. L. E. Haentzschel,* Appleton, who has resigned the post to join the staff of the Taunton State Hospital in Taunton, Mass.

Two Hospitals Choose New Officers

New president of the staff of Victory Memorial Hospital in Boyd is *Dr. P. B. Jorgensen* of Thorp. Other officers elected at the staff meeting on January 8 include *Dr. J. W. Johnson* of Withee, vice president; and *Dr. Eleanora F. Jorgensen* of Thorp, who will serve as secretary-treasurer.

At a meeting of the medical staff of St. Joseph's Hospital in Dodgeville January 20, the following officers were elected for the coming year: *Dr. H. H. Morton,* president, and *Dr. H. M. Walker,* vice president, both of Dodgeville; and *Dr. W. D. Hamlin,* Mineral Point, secretary.

Dr. Roy C. Glise Joins Richland Clinic

Dr. Roy C. Glise, a native of Decorah, Iowa, has joined the staff of the Edwards Clinic in Richland Center. A graduate of Luther College in Decorah

and of the State University of Iowa College of Medicine in Iowa City, Doctor Glise interned at Des Moines and served a surgical residency at the Gundersen Clinic in La Crosse from 1950 to 1951. He was recently discharged from the Army after 18 months of duty in Korea.

Dr. A. H. Heidner Speaks on Retardation

At a meeting in West Bend February 9 of the Washington County Association for Mentally Retarded Children *Dr. A. H. Heidner* gave a talk entitled "The Family Doctor Looks at Retardation."

Immediate past-president of the State Medical Society, Doctor Heidner is chief of the surgery department of St. Joseph's Hospital in West Bend.

Dr. Joseph Matt Opens Oconomowoc Office

An office for the practice of medicine and general surgery has been opened in Oconomowoc by *Dr. Joseph Matt*, a former member of the staff of the Carle Clinic in Urbana, Ill.

Doctor Matt is a graduate of Marquette University and the Marquette University School of Medicine. After interning at St. Joseph's Hospital in Milwaukee, he served for 26 months in the medical corps of the Army. Upon his release from the Army he took a postgraduate course in surgery and was resident surgeon for three years at St. Joseph's Hospital in Parkersburg, Va.

Hazel Green Clinic Has New Staff Member

Dr. William G. Gillies, a native of Long Island, New York, has joined the staff of the Hazel Green Clinic in Hazel Green.

Recently discharged from the Army Medical Corps, Doctor Gillies is a 1949 graduate of the Louisiana State University School of Medicine. After interning at the Jersey City (N. J.) Medical Center, he took further training at the Margaret Hague Hospital in obstetrics and infant diseases.

Hartford Executive Board Re-elected

At the annual staff meeting of the Hartford Hospital on January 13, *Drs. W. C. Philip Hoffmann, V. V. Quandt,* and *Maurice E. Monroe* were elected to serve for another year as members of the executive board of the hospital. Doctor Hoffmann will continue as chief of staff, Doctor Quandt as vice president, and Doctor Monroe as secretary-treasurer.

Two new committees were formed at the meeting. Doctor Quandt, assisted by *Drs. J. E. Albrecht,* Jackson, and *Earl O. Quackenbush,* will head the record and nomination committee. Doctor Monroe and *Dr. Theodore Kern,* Richfield, will serve as members of the new consultative committee. Except where otherwise noted, all of the physicians are from Hartford.

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

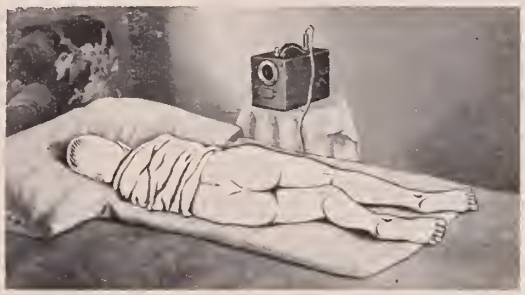
Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN



NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY

525 Holly Avenue, Madison 5, Wisconsin

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

To Serve Your Complete Prosthetic & Orthopedic Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Western Electric HEARING AID

Air and Bone Conduction

There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.

Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE

AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

Dr. Aloysius Hickey Takes La Crosse Posts

Dr. Aloysius Hickey, specialist in internal medicine, has recently joined the staff of St. Francis Hospital in La Crosse and the La Crosse Clinic.

A native of La Crosse, Doctor Hickey was graduated from the University of Wisconsin Medical School in 1943 and served his internship at the hospitals and clinics of the University of Oregon. After two years in the Army Medical Corps on active duty in France, Germany, and Austria, he returned to civilian life in September 1946 and began a three-year residency in internal medicine at the Veterans Administration Hospital in Wood. For the three years before his present appointment he practiced at the Veterans Administration regional office in Green Bay.

Doctor Pfeiffer Opens Turtle Lake Office

Dr. Louis R. Pfeiffer, a 1951 graduate of the University of Wisconsin Medical School, has set up independent practice in Turtle Bay. Before opening his office on February 23, Doctor Pfeiffer was associated with the Cumberland Clinic in Cumberland.

Sons of Dr. J. F. Bennett Accept Posts

Dr. John C. Bennett and Dr. James Bennett, sons of *Dr. J. F. Bennett* of Burlington, have accepted new positions for the coming year. John, now completing his residency in radiology at Temple University Hospital in Philadelphia, will report shortly after June 30 to the University of California Medical School, where he will serve as instructor in radiology and assistant radiologist at the University of California Hospital in San Francisco. On July 1, James will start his residency in surgery at the University of Michigan Hospital in Ann Arbor. Recently released from active duty with the Navy, James is now working with *Dr. C. J. Garding* in Jefferson.

THIRD AND TWELFTH DISTRICTS NEWS

Jackson Clinic Takes Two New Members

Two new physicians, Dr. Lee B. Stevenson and Dr. Lloyd Gilman, have joined the staff of the Jackson Clinic and Methodist Hospital.

Doctor Stevenson will be associated with *Dr. Addie M. Schwittay* in the department of gynecology and obstetrics. A 1946 graduate of the University of Illinois College of Medicine in Chicago, Doctor Stevenson served a year's internship at Pontiac (Mich.) General Hospital. After two years in the Air Force Medical Corps, he was a resident for 3½ years at Pontiac General Hospital and at St. Luke's Hospital in Chicago.

Doctor Gilman will spend the year in postgraduate study in the department of surgery. For several years he was engaged in private practice in

Willman, Minn., where he was associated with the Lakeland Medical Center. A graduate of the University of Minnesota Medical School in 1938, he interned at Minneapolis General Hospital. He spent 4½ years in the Army Medical Corps.

Cancer Committee Hears Talk

Dr. Oscar F. Foseid, Madison, was the guest speaker at a recent meeting of the Eastern Dane County Cancer Committee, held at the Legion Hall in Sun Prairie. Doctor Foseid, who is associated with the tumor clinic at the State of Wisconsin General Hospital, chose "Present Status of the Fight Against Cancer" as the title of his presentation.

Doctor Lemmer Attends Chicago Meeting

Dr. Kenneth E. Lemmer of Madison attended the March meetings of the Central Surgical Association at the Drake Hotel in Chicago. The doctor is an associate professor of surgery at the University of Wisconsin Medical School. At the close of the meeting Dr. and Mrs. Lemmer left from Chicago for a southern vacation.

Doctor Stovall Addresses Mother's Club

On March 2, *Dr. W. D. Stovall* addressed a meeting of the Marquette Mother's Club in Madison. The doctor urged his audience to maintain a constant vigilance to prevent diseases in youngsters and advised regular physical examinations. Doctor Stovall, director of the State Laboratory of Hygiene, was recently honored at a testimonial dinner climaxing the day of the formal opening of the new state laboratory.

Sauk

The Sauk County Medical Society heard a speech by *Dr. M. J. Musser,* Madison, on "The Status of Civil Defense" at its March 10 dinner meeting in the Warren Hotel. The doctor is chairman of the Committee on Civil Defense of the State Society.

Three UW Fraternities Sponsor Lectures

Three University of Wisconsin medical fraternities recently sponsored lectures at the auditorium of the Service Memorial Institute.

Dr. P. C. Hodges, professor of radiology at the University of Chicago School of Medicine, presented the annual Alpha Omega Alpha lecture. The title of his talk was "Fibrous Dysplasia of Bone."

On March 11, Phi Delta Epsilon sponsored the annual Arthur S. Loevenhart Lecture. "Endocrine Regulation of the Blood Sugar, with Particular Reference to Diabetes Mellitus" was the title of a talk presented by the guest speaker, Dr. J. W. Conn of Ann Arbor, Mich. The doctor is a professor of medicine at the University of Michigan.

Dr. K. K. Chen of Indianapolis was the guest speaker sponsored by Phi Chi. The doctor, who is

Do You Intend to Be A Financial Failure at 65?

WHO ever heard of such a silly question! Nobody intends to end up that way.

But, dear reader, the facts of life are stubborn. Too many men, and lots of them who once were a big success, just don't make the grade. We don't start saving soon enough.

Why do you suppose Social Security came into being? It forces us to save a little for old age, but we all know that we just can't live on that. Nor was it so intended. It is just a starter from which to build a better and more adequate retirement for ourselves.

It is later than you think. Good things don't just happen. Start now to make sure you'll be secure at 65. A Wisconsin Life Retirement Income contract will guarantee it for you. Consult one of our representatives for details without obligation.

WISCONSIN LIFE INSURANCE CO.
30 W. MIFFLIN ST. MADISON, WIS.

Distributors to the profession

of fine

Injectable Vitamins and Endocrines

Interstate Pharmacal Company

P. O. Box 252 Beloit, Wis.

MAIL ORDERS SHIPPED IMMEDIATELY

BARR X-RAY CO.

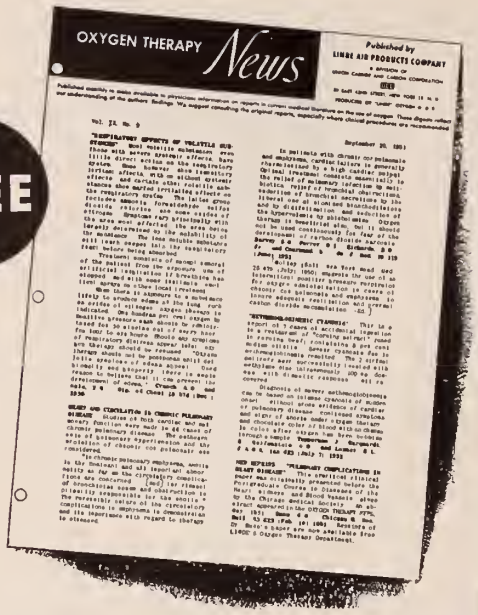
Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin



FREE

What's New in Oxygen Therapy?

It's easy for physicians to keep abreast of new developments in oxygen therapy, as reported in current medical literature, by reading the OXYGEN THERAPY NEWS, published monthly by Linde Air Products Company.

Arrange to receive this informative publication, free of charge or obligation, by calling any of the LINDE distributors listed below.

AVAILABLE FROM ANY OF THESE DISTRIBUTORS OF

Linde OXYGEN U.S.P.

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding and Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS LITER FLOW ADAPTORS • OXYGEN THERAPY ADMINISTERING EQUIPMENT

director of pharmacologic research at the Eli Lilly Research Laboratories and professor of pharmacology at Indiana University, chose "Racial and Species Differences of Drug Action" as the title of his paper.

Doctor Sargent Addresses Oklahoma Medical Association

J. C. SARGENT

Dr. James C. Sargent of Milwaukee was one of the guest speakers on the program of the annual meeting of the Oklahoma State Medical Association. The meeting was held in Tulsa on April 13, 14, and 15. "Bladder Tumors: Their Diagnosis and Treatment" and "Urolithiasis" were the titles of two papers presented by Doctor Sargent. The doctor also participated in a round-table discussion.

During the weekend of March 14, Doctor Sargent attended a meeting in Washington, D. C., of the Health Resources Advisory Committee to the Office of Defense Mobilization. He then flew cross country to Las Vegas, Nev., for preliminary briefing before witnessing the atomic bomb explosion on March 17.

MU Honors Dr. Max Fox

M. J. FOX

Dr. Max J. Fox, medical director of South View Hospital, was honored as the "alumnus of the year" by the Marquette University School of Medicine Alumni Association at its spring clinic on March 28. He was selected for the award by the executive committee of the association.

The doctor also is associate professor of internal medicine at Marquette, where he has taught since his graduation in 1922. He is a diplomate of the American Board of Internal Medicine.

Milwaukee

The Wisconsin Heart Association sponsored three prominent speakers for the February 12 meeting of the Medical Society of Milwaukee County. Choosing rheumatic fever as their subject, the speakers were

Dr. Edward Bland of the Massachusetts General Hospital and the Harvard Medical School, Dr. Albert Dorfman of the University of Chicago and the La Rabida Sanatorium, and Dr. Lewis Thomas of the University of Minnesota.

This was the fourth meeting of the medical society sponsored by the Lucy Ann Droessel Memorial Fund of the Wisconsin Heart Association. These annual meetings are reserved for talks on cardiovascular diseases.

Milwaukee Academy of Medicine

Dr. Marvin H. Pollard, professor of internal medicine at the University of Michigan Medical School, was the guest speaker at the March 17 meeting of the Milwaukee Academy of Medicine. His subject was "Treatments to Avoid in the Management of Peptic Ulcer."

Milwaukee Neuro–Psychiatric Society

The March 18 meeting of the Milwaukee Neuro-Psychiatric Society featured two guest speakers. Dr. D. M. Bullard, medical director of Chestnut Lodge, Rockville, Md., spoke on "Use of Psychoanalytic Principles in the Care of Psychotic Patients." Dr. P. B. Reed of the Norways Foundation, Indianapolis, Ind., chose "Some Medico-Legal Aspects of Electroshock" as the title of his presentation.

Milwaukee Oto–Ophthalmic Society

The University Club was the site of the February 24 dinner meeting of the Milwaukee Oto-Ophthalmic Society. *Dr. Sidney K. Wynn* of Milwaukee was the speaker during the scientific part of the meeting. The title of his talk was "Primary and Secondary Repair of Facial Injuries."

SOCIETY RECORDS

New Members

O. E. Larson, 44½ South Main Street, Clintonville.

P. S. Haskins, River Falls Clinic, River Falls.

P. Arthur Heiser, Woodville.

J. N. Moore, 20 Sherman Terrace, Madison.

R. E. O'Connor, 310 North Orchard Street, Madison.

E. W. Cauldwell, 431 Olympian Boulevard, Beloit Municipal Hospital, Beloit.

Yoshio Handa, Kraemer Building, Plain.

H. V. Capparell, 1220 Dewey Avenue, Wauwatosa.

A. M. Kurzon. 425 East Wisconsin Avenue, Milwaukee.

J. E. Ramin, 4216 West Burleigh Street, Milwaukee.

Abe Sosman, Veterans Administration Center, Wood.

C. B. Moen, Galesville.

ROEMERS—MILWAUKEE

Surgical Supplies
Hospital Supplies
Office Furniture
Laboratory Supplies

* * *

Complete Service to the Medical Profession

* * *

Roemer Drug Company
606 No. Broadway
Milwaukee 2, Wisconsin

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

RADIUM and RADIUM D+E
(Including Radium Applicators)
FOR ALL MEDICAL PURPOSES
Est. 1919

Quincy X-Ray and Radium Laboratories
(Owned and Directed by a Physician–Radiologist)

HAROLD SWANBERG, B. S., M. D., Director
W. C. U. Building Quincy, Illinois

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses - 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting April 13, April 27, May 11
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks starting June 1
Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17
Gallbladder Surgery, Ten Hours, starting April 20
Surgery of Colon & Rectum, One Week, starting April 13
General Surgery One Week, starting May 4
General Surgery, Two Weeks, starting April 20
Thoracic Surgery, One Week, starting June 8
Breast & Thyroid Surgery, One Week, starting June 22
Esophageal Surgery, One Week, starting June 22
Fractures & Traumatic Surgery, Two Weeks, starting June 15
GYNECOLOGY—Intensive Course, Two Weeks, starting April 20
Vaginal Approach to Pelvic Surgery, One Week, starting May 4
OBSTETRICS—Intensive Course, Two Weeks, starting June 8
PEDIATRICS—Congenital Heart Disease, Two Weeks, starting May 18
Cerebral Palsy, Two Weeks, starting June 15
MEDICINE—Intensive General Course, Two Weeks, starting May 4
Electrocardiography & Heart Disease, Two Weeks, starting July 13
Allergy, One Month and Six Months, by appointment
CYSTOSCOPY—Ten-Day Practical Course starting every two weeks
DERMATOLOGY—Intensive Course, Two Weeks, starting May 11

Teaching Faculty—Attending Staff of Cook County Hospital
Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

Your Visit to Milwaukee

Is Made More Enjoyable by Stopping at the SCHROEDER

Metropolitan atmosphere
Cocktail Lounge
Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

Harry Ageloff, 610 Sixth Street, Racine.
W. C. Miller, St. Mary's Hospital, Racine.
B. T. Bonell, 6820 14th Avenue, Kenosha.

Changes in Address

Nathan Tolwinsky, Cudahy, to 2747 North 49th Street, Milwaukee.

R. G. Welsch, Milwaukee, to 155 West Adams Street, Creston, Iowa.

H. E. Schaefer,* Big Spring, Texas, to 414 North Eighth Street, Manitowoc.

R. A. Flynn,* Camp McCoy, to 0992042, A.P.O. 201 % Postmaster, San Francisco, California.

D. K. Buffmire,* Camp McCoy, to U. S. Army Infirmary, Fort Sheridan, Illinois.

G. H. Lohrman,* Nurnberg, Germany, to 01921077, Third Armored Medical Company, A.P.O. 46, % Postmaster, New York, New York.

C. J. Hipps, Denmark, to Northern Building, Green Bay.

S. B. Crepea,* Geneva, New York, to 3D Hospital Group, A.P.O. 179, % Postmaster, New York, New York.

L. G. G. Glasson, Miami, Florida, to 925 East Wells Street, Milwaukee.

W. J. Hanley, West Allis, to 716 North 11th Street, Milwaukee.

F. N. Peterson, Milwaukee, to 930 Fourth Street, Bismarck, North Dakota.

J. A. Johnson,* Milwaukee, to 50–21st Army Service Unit, U. S. Army Hospital, Ft. Riley, Kansas.

J. A. Means, Rolla, Missouri, to 2637 North 41st Street, Milwaukee.

T. J. Dredge, Yankton, South Dakota, to Eastern Shore State Hospital, Cambridge, Maryland.

R. P. Still, DeKalb, Illinois, to 435 Sherwood Drive, LaGrange Park, Illinois.

W. A. Mudge, Hines, Illinois, to 2400 Belvidere, Waukegan, Illinois.

Dorothy H. W. Oakley, Madison, to 5 Alexander Avenue, Clinton, Massachusetts.

J. W. Koch, Owen, to Colby.

F. F. Nelson, Colby, to St. Vincent's Hospital, New York, New York.

P. E. Hanlon,* Janesville, to U.S.A.R., 3441 Army Service Unit, U. S. Army Hospital, Camp Gordon, Georgia.

---

* Military service.

DEATHS

Dr. Roscoe Lyle McIntosh died suddenly, at the age of 61, on November 18, 1952. At the time of his death he was associate professor of dermatology and syphilology at the University of Wisconsin Medical School, a position he had held since 1937. In addition to his association with the University, he maintained an office in the Tenney Building, Madison, for the private practice of dermatology.

In 1919 Doctor McIntosh graduated from the University of Wisconsin and in 1921 from the Washington University School of Medicine in St. Louis. After completing an internship at the Wisconsin University Hospital Student Infirmary, he went to the Barnard Skin and Cancer Hospital in St. Louis and then to London to take a postgraduate course in dermatology and syphilology. In 1923 he returned to the University of Wisconsin Medical School as an instructor in dermatology.

Among Doctor McIntosh's varied interests was the study of arsenic and its relation to the production of skin diseases. He had taken work at the University Law School and gave lectures in legal medicine at the University of Wisconsin Medical School. Before his death he completed a text book on legal medicine, designed for Wisconsin medical students and physicians, which deals with the relationships of physicians to the laws of this state. At the time of his death he was working on the manuscript for a dictionary of dermatology. Doctor McIntosh had always been interested in the exact definition of terms.

In addition to his active interest in medicine, Doctor McIntosh was interested in all of the University's athletic events, particularly boxing. In 1952 he was presented with a Golden Glove by friends of the boxers, an honor which previously had been given only to members of the boxing team. For years his home was the stopping place for coaches of the visiting boxing teams and boxing officials, and he was always interested in the individual boxers, frequently lending them a helping hand.

Born in Edgerton, Doctor McIntosh was educated in the public schools there. In 1918 he was married to Helen Coon, who survives him. His son James is now a resident in urology at the University Hospitals in Madison.

His Scotch humor and practical teaching will be missed by all of us. *(Prepared for the Journal by Dr. Garrett A. Cooper)*

Dr. Lloyd O. Helmes, Oshkosh pediatrician and obstetrician, was killed February 12 when the private plane in which he and his wife were traveling crashed and burned just after take-off from Morrow Field in Colton, California. Doctor Helmes was 63.

A native of New Ulm, Minnesota, Doctor Helmes was a graduate of the University of Wisconsin and the Washington University School of Medicine in St. Louis, Missouri. Before establishing his practice in Oshkosh in 1926, he practiced in Monticello, Rhinelander, and Monroe.

Doctor Helmes was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors of the couple are their three daughters, Mrs. Jean Anderson of Fontana, California; Jo Ann, a student at the University of Wisconsin; and Lois, a student at Marquette University.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 **Milwaukee, Wis.**

Dr. Francis J. Donnelly, pioneer Waukesha County general practitioner, died February 1 at his home in North Lake after a month's illness. He was 89.

Born on a farm near Monches, Doctor Donnelly returned to set up practice there shortly after his graduation from the Northwestern University Medical School in 1891. For over fifty years he practiced in Monches and in North Lake, where he lived after his Monches home burned in 1930. In 1941, after he had completed fifty years of practice, the entire community of Monches sent him an open letter thanking him for his service. He retired about five years ago.

A member of county and state medical societies and of the American Medical Association, Doctor Donnelly received the pin of the Fifty Year Club of the State Medical Society in 1948.

Doctor Donnelly is survived by his wife and a sister, Miss Theresa Donnelly of Milwaukee.

DEMONSTRATIONS FOR 1953 ANNUAL MEETING ANNOUNCED

Dr. Maurice Rice, Stevens Point, a member of the Council on Scientific Work, announces that the following demonstrations will be held each morning of the Annual Meeting, Tuesday, Oct. 6 through Thursday, Oct. 8 from 9:00 to 10:00 a. m.:

Ob & Gyn: Movies and manikin demonstrations on special problems associated with deliveries. Planned in conjunction with Wisconsin Society of Obstetrics and Gynecology.
Fractures: Application of casts by members of the Wisconsin Society of Orthopedists.
Cerebral Palsied Child: Demonstrations (with children) by the Wisconsin Assn. for Disabled and the Milwaukee Cerebral Palsy Clinic.
Gross Pathology: Tissue displays and lectures by members of the Wisconsin Society of Pathologists.
Anatomy Dissections: By Marquette University Department of Anatomy.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Complete office equipment of General Practitioner which includes examining table, instrument and drug cabinets, steel filing cabinet, sterilizer, scales, microscope, desk, chairs, book cases, etc., all in excellent condition. Doctor retiring because of ill health. Address replies to Dr. Edward Jackson, 931 W. Walnut St., Milwaukee, Wis. Phone Lo. 2–5144.

WANTED: General practitioner as associate in central Wisconsin. Excellent hospital facilities. Unlimited opportunity. Salary at first, partnership later. Address replies to Box 486 in care of the Journal.

FOR SALE: One 20 ma Profexray mobile x-ray unit, very reasonably priced. Also one Kelley Koett mobile x-ray unit, like new. Address replies to Downs X-Ray Company, 1004 N. Jackson St., Milwaukee 2, Wis. Phone BR. 2–7050.

DETAILING PHYSICIANS wanted to call on physicians and hospitals in eastern and southern Wisconsin. Outstanding, noncompetitive new product with AMA acceptance. Address replies to Q-Test Distributors of Minneapolis, 5921 Dupont Ave. S., Minneapolis 19, Minn.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE: One 20 ma Fischer x-ray mobile unit, bucky table, and other complete accessories. Excellent condition. Very reasonable. Address replies to Box 487 in care of the Journal.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

WANTED, otolaryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2–8118.

WANTED: Used hospital size Bovle Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5–9100.

PHYSICIAN WANTED as associate in busy, successful practice including surgery in rural, resort, and railroad town of 3,000 in northwest Wisconsin Indianhead region. Fully equipped 13-room modern brick clinic started April 15. Excellent hospital facilities near-by. Local hospital building campaign under way. Salary, percentage, or guaranteed minimum basis initially, with eventual partnership. Address replies to Lester J. Olson, M. D., Spooner, Wis.

FOR SALE: Practice of the late Dr. J. J. Fitzgerald, Eagle, Wis. Beautiful modern home, office in residency with separate entrance. No competition. Physician badly needed. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

WANTED: Physician as an associate in general practice, preferably with surgical training and service exempt. City of 10,000 population in north central Wisconsin, with excellent hospital facilities and on a salary basis with eventual partnership. Address replies to box 473 in care of the Journal.

FOR SALE: Optometric equipment in good location for a physician who does refraction. Equipment valued at $600. Address replies to box 474 in care of the Journal.

WANTED: Pediatrician, or general practitioner willing to do large share of pediatrics, in an active group practice in suburban Milwaukee. Address replies to box 475 in care of the Journal.

FOR SALE: Hellige colorimeter for blood sugars, with glassware but no chemicals, $15. Also cystoscopy 3-cell battery box, $10. Address replies to R. M. Rogers, M. D., Tigerton, Wis.

GENERAL PRACTITIONER, middle-aged with extensive experience, desires association or location. Available about June 1, 1953. Address replies to box 476 in care of the Journal.

PHYSICIAN WANTED, preferably one with one or two years experience in private practice, as an associate in a well established general and surgical practice in a city of over 30,000. Address replies to box 478 in care of the Journal.

PHYSICIANS AND PEDIATRICIANS, with or without public health training, needed in Maternal and Child Health program at salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Address replies to E. R. Krumbiegel, M. D., City Hall, Milwaukee, Wis.

CLINIC in Milwaukee needs general practitioner, internist, and pediatrician. Address replies to Box 488 in care of the Journal.

WANTED: Urological table with built-in bucky. Must be relatively new and in good condition. Address replies to Milton Margoles, M. D., 1971 W. Capitol Dr., Milwaukee, Wis.

RADIOLOGIST with ten years' experience, Board certified, desires opportunity for group practice or contact with men interested in forming group. Address replies to Box 489 in care of the Journal.

LOCATION WANTED: General practitioner, age 28, married, family, desires assistantship, association, or location. Completing 24 months active duty in Army on April 1. Licensed in Wisconsin. Graduate of U. of Wisconsin Medical School. Has own office furniture and equipment. Address replies to box 481 in care of the Journal.

WANTED: Associate in general practice in a community of 30,000. Internist or well trained G.P. Percentage basis. Address replies to box 482 in care of the Journal.

ASSOCIATION WANTED in general practice. Graduate Washington U. School of Medicine, 1951; 1 year rotating internship; 1 year pediatrics; 27 years old, married; priority IV. Address replies to P. L. Wachtel, M. D., St. Louis City Hospital, St. Louis, Mo.

Wanted RESIDENT PHYSICIAN: Large Institution for Mentally Deficient located in nice residential section of thriving city of 140,000. Practice can be limited to General Medical Services but there is opportunity for experience in Pediatrics and moderate amount of Surgery. Good salary, liberal time off for week ends, holidays, sick leaves, and vacations with full pay. Full maintenance for man and wife. (Quarters not available for children at this time.) Night work at a minimum. Moderate physical handicaps no bar to employment. Address replies to Superintendent, Fort Wayne State School, Fort Wayne 1, Ind.

ASSOCIATION WANTED: Physician who is tired of solo practice desires association with physician or group to do general practice. Address replies to box 483 in care of the Journal.

POSITION OPEN for associate interested in obstetrics and general practice in a clinic. Substantial retirement program and opportunity to become member of association without "buying in." Salary open. Facilities of two hospitals available. Address replies to box 484 in care of the Journal.

FOR SALE: Electro Hemometer with two cells and two pipets. Instrument like new. Price $45. Address replies to C. F. Ulrich, 625 57th St., Kenosha, Wis.

POSITION OPEN for physician on a locum tenens basis for a period of a year or two in a clinic. Salary open. Facilities of two hospitals available. Address replies to box 485 in care of the Journal.

HOUSE DOCTOR WANTED: Eight hours daily, afternoons and evenings; $350 to $400 monthly. Write or phone J. P. Nothum, Doctors Hospital, 2711 W. Wells St., Milwaukee, Wis. Phone DI 2–9310.

WANTED: Medical technologist, registered. Opportunities for research and advancement. Very pleasant working conditions. Thirty-five hour week. Address replies to Junior League Blood Center, 763 North 18th St., Milwaukee, Wis.

535 North Dearborn Street, Chicago 10, Illinois

AMERICAN MEDICAL ASSOCIATION news notes APRIL 1953

AMA news written especially for use in state medical journals

Dr. McCormick's Inaugural to Be Broadcast Nationwide

The presidential inaugural address of Dr. Edward J. McCormick will be broadcast nationwide on Tuesday evening, June 2. The program will originate from the Commodore Hotel, New York, during the AMA's 102nd annual meeting. Immediately after the ceremony, a reception honoring the new president will be held in an adjoining ballroom.

Last Call for Palace!

This June may be your last chance to wander at will through New York's Grand Central Palace! The AMA's scientific and technical exhibitions will be one of the last of the "private" meetings to be held there. Some time in the fall the Palace will be taken over by the US Bureau of Internal Revenue for office space. The 1953 Technical Exposition will feature displays from more than 350 manufacturing, drug, and publishing firms, while the Scientific Exhibit will present approximately 260 clinical and diagnostic exhibits.

SAMA June Convention Program Set

Panel discussions devoted to doctor draft, general practice, and SAMA chapter activities will highlight the third annual convention of the Student American Medical Association. More than 1,000 registrants are expected to attend the meeting June 15, 16, and 17 at the Edgewater Beach Hotel, Chicago.

The tentative program announced by President David Buchanan, University of Illinois senior, calls for official business of the House of Delegates on Monday, June 15. That night Abbott Laboratories will be hosts at an informal get-together. Tuesday's program will feature the above panel discussions in the morning and tours of AMA Headquarters in the afternoon. Election of officers and a premiere of an outstanding medical film are on the docket for the last day of the meeting. A large technical exhibit will make its initial appearance at a SAMA convention this year. All AMA members are cordially invited to attend the sessions.

PR Aid—"Your Doctor" Film

Tops on the list of 1953 public relations aids for medical societies is the "Your Doctor" film. Local societies are urged to continue its promotion through two channels: (1) encourage commercial theaters to book the film through RKO–Radio Pictures; (2) arrange showings of the 16-mm. version to all segments of the community.

In most areas, a brief announcement of the availability of "Your Doctor" will stimulate a continuing demand. The 16-mm. version can be booked in two ways. The AMA has arranged for Modern Talking Picture Service to handle orders throughout the country. The only charge is for postage and insurance. The second booking method is through state and county societies. Individual prints may be secured at $70 per copy from RKO–Radio Pictures and requests filled by society offices. Purchase 16-mm. prints from Mr. Arthur M. Good, RKO–Radio Pictures, 1270 Avenue of the Americas, New York, N. Y.

Name AMA Delegates to World Medical Meetings

AMA representatives to two important world medical meetings—the World Medical Association and the First World Conference on Medical Education—have been announced by the Board of Trustees.

Delegates, alternates, and observers to the World Medical Association meeting to be held August 31–September 4, 1953, at The Hague, The Netherlands, include: Drs. Gunnar Gundersen, E. S. Hamilton, Dwight H. Murray, F. J. L. Blasingame, George F. Lull, and Austin Smith.

The following representatives will attend the First World Conference on Medical Education August 24–29, 1953, in London: Drs. Donald G. Anderson, Herman Weiskotten, Victor Johnson, E. S. Hamilton, and Austin Smith.

Ralph P. Creer, secretary of the Committee on Medical Motion Pictures, has been invited to speak on "Motion Pictures in Medical Education" at the London conference. His paper will include a discussion of the value of motion pictures in medical teaching and the international exchange of medical films.

New Exhibit Shows How Medical Dollars Are Spent

A new exhibit showing how the medical care dollar is distributed among physicians, hospitals, druggists, dentists, and others is now available through the AMA's Bureau of Exhibits. "Where Your Medical Dollar Goes" features three-dimensional figures on a revolving pedestal. Available to state and county medical societies, this exhibit may be shown either in conjunction with such exhibits as "Health Today" and "Your Medical Care" or by itself.

Newscopes

A check for $5,000 was forwarded to the Netherlands medical association for *flood relief*. . . . The AMA's Committee on Blood has joined with the American Red Cross in forming a joint *fact-finding committee* to arbitrate differences between community blood banks and area Red Cross offices. This committee will make recommendations if invited to do so by either local medical societies or Red Cross chapters. . . . *Liaison committee* composed of Drs. James R. McVay, chairman, David B. Allman, and Gunnar Gundersen has been appointed by the Board of Trustees to work with the Association of State and Territorial Health Officers. . . .

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc.
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors -- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate -- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

Page

Abbott Laboratories ---------- 10, 11, 25
Audiphone Utilities ---------- 34
Ayerst, McKenna & Harrison, Ltd. ---------- 12

Baker Laboratories ---------- 6
Barr X-Ray Company ---------- 35
Benson Optical Company ---------- 20
Bergmann Prescription Center ---------- 16

Central Drug ---------- 16
Ciba Pharmaceutical Products, Inc. ---------- 17
Coca Cola Company ---------- 4
Cook County Graduate School of Medicine ---------- 38

Doerflingers ---------- 37

Endocrine Laboratories ---------- 33

Hotel Schroeder ---------- 38
House of Bidwell ---------- 34
Hurley X-Ray Company ---------- 34

Interstate Pharmacal Company ---------- 35

Junior League Blood Center ---------- 32

Keeley Institute ---------- 8
Kennedy–Mansfield ---------- 16

Lederle Laboratories ---------- facing page 18
Lilly, Eli and Company ---------- 22
Linde Air Products ---------- 36

Mallard, Incorporated ---------- 13
Mallatt Pharmacy ---------- 16
Mather Pharmacy ---------- 16
Mayer Drug ---------- 16
Mead Johnson and Company ---------- 45
Medical Protective Company ---------- 8
Merck and Company ---------- 15
Milwaukee Sanitarium ---------- 46

New York Polyclinic ---------- 28
Nichols, John, Inc. ---------- 245

Orgo Products Company ---------- 8
Orthopedic Appliance Company ---------- 39

Parke, Davis and Company ---------- 2, 3
Pfizer, Charles and Company, Inc. ---------- 7
Physicians Casualty Association ---------- 14
Pogue, Mary, School ---------- 5
Professional Business Service ---------- 243

Q-Test Distributor of Minneapolis ---------- 18
Quincy X-Ray & Radium Laboratories ---------- 37

Rennebohm's ---------- 16
Roemer Drug Company ---------- 37
Rogers Memorial Sanitarium ---------- 46

S. and L. Signal Company ---------- 33
Sacred Heart Sanitarium ---------- 14
St. Croixdale Sanitarium ---------- 5
Schering ---------- 19
Schieffelin and Company ---------- 32
Searle, G. D. and Company ---------- 23
Shorewood Hospital Sanitarium ---------- 31
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp. ---------- 9
Stanley, Inc. ---------- 5
Summit Hospital ---------- 20

Time Insurance Company ---------- 241

Upjohn Company ---------- 29

Winthrop–Stearns, Inc. ---------- 21
Wisconsin Life Insurance Company ---------- 35

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	H. W. Harris Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.

** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 MAY 1953 Number 5

Needle Biopsy of the Liver

By D. M. BUCHMAN, M. D.
La Crosse

IN SPITE of the number and variety of laboratory tests of liver function, we frequently are unable to establish a diagnosis until the organ has been exposed to direct view and specimens have been obtained for microscopic study.

In many instances conditions are found for which surgery is of no benefit. Therefore, a method that will furnish the needed information and save the patient a useless surgical exploration should become popular, provided it is free from undesirable features.

In our experience needle biopsy of the liver has met the requirements for safety, simplicity, and effectiveness. We wish to report our results in 12 patients seen from 1947 to 1952.

Conforming to the customary indications and contraindications, we followed the technic described by Cogswell and Schiff.[1] We used the "Vim"—Silverman needle and entered the liver either by the intercostal or the subcostal approach.

CASE 1—T. G., a 78 year old white male, was examined in 1947 because of anorexia and a 30 pound weight loss in six months. The liver was greatly enlarged, extending to the crest of the ilium, and was smooth and nontender. The serum globulin was elevated and the albumin-globulin ratio reversed. The icterus index, hemogram, cholesterol and ester, and urinary urobilinogen were normal. Needle biopsy was done. The pathologic report was hepatic carcinoma, liver cell type. Treatment was palliative, the course was downhill, and death occurred two months later. Autopsy confirmed the diagnosis of hepatic carcinoma.

CASE 2—C. D., a 44 year old white male bartender, came under observation in 1947. He had been a heavy drinker for 20 years. His symptoms included diarrhea, and abdominal cramps and distention. He had dilated superficial abdominal veins, hepatomegaly, splenomegaly, hypochromic anemia, and increased urinary urobilinogen. Liver biopsy resulted in a histopathologic diagnosis of advanced fatty metamorphosis and moderate cirrhosis (Fig. 1). In the fall of 1952 he had ascites but the liver was not palpable. His cooperation was poor and he refused to stop drinking.

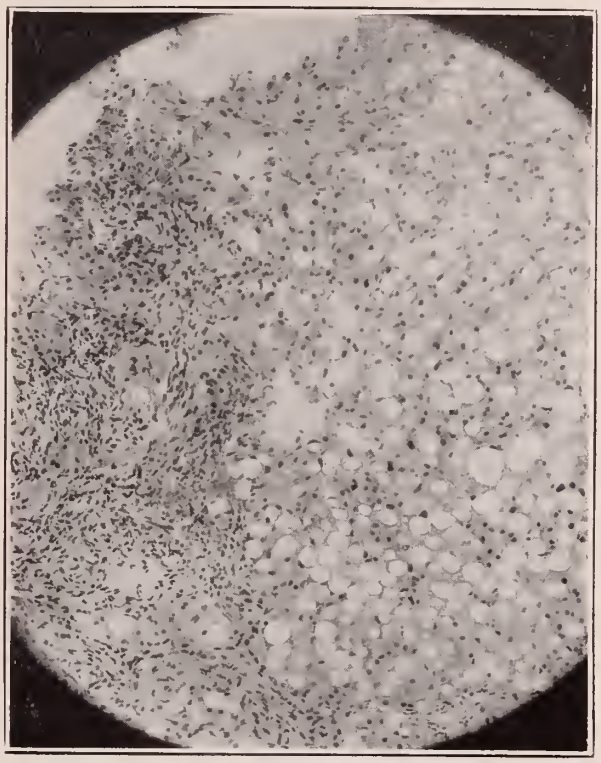


Fig. 1—Fatty metamorphosis and cirrhosis. Note distortion of liver lobules by fibrosis, at the left of the field.

Comment. The clinical course confirmed the diagnosis of Laennec's cirrhosis. The disease progressed to an irreversible stage.

CASE 3—G. K., a 65 year old white male, entered the hospital in 1950 complaining of an epigastric mass of one month's duration.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

The mass was an enlarged liver. After extensive laboratory and x-ray investigation the diagnosis was still doubtful and needle biopsy was performed. This revealed metastatic carcinoma, primary probably in the extrahepatic or gastrointestinal tract. Treatment was palliative and death occurred eight months later. Permission for autopsy was not obtained.

CASE 4—W. D., a 65 year old white male, had apparently been in good health until two weeks before hospitalization in 1950. His symptoms were diarrhea, anorexia, and weakness. He had hepatomegaly, a firm mass in the cecal area, and a mild hypochromic anemia. No occult blood was found in the stool. Chest x-ray was negative. Colon x-ray revealed an obstruction in the ascending colon, interpreted as probably due to a neoplasm. Liver biopsy resulted in a diagnosis of metastatic carcinoma, primary probably in the intestine (Fig. 2). The patient died two months later at home.

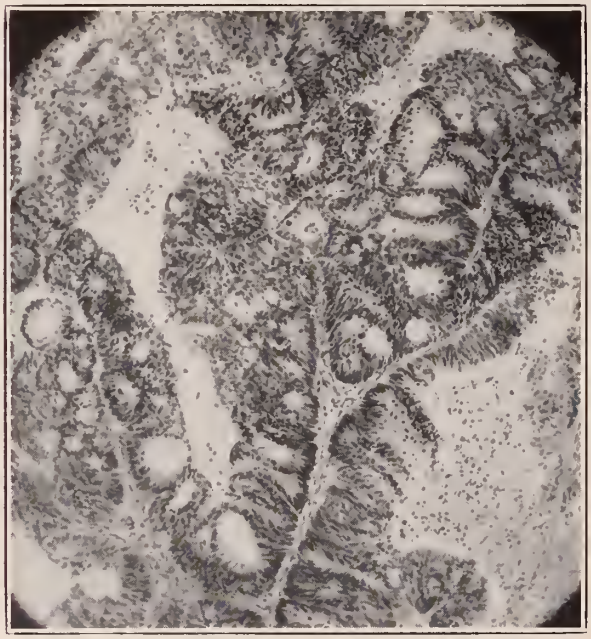


Fig. 2—Metastatic adenocarcinoma in the liver.

Comment. Needle biopsy permitted a definite diagnosis in cases 3 and 4. In both patients exploratory laparotomy was avoided.

CASE 5—F. P., a 69 year old white male, was hospitalized in 1950 because of pain in the upper abdomen of 10 days' duration. He denied weight loss, anorexia, or a change in bowel habits. He had faint icterus and an enlarged, hard liver extending to the navel. The stomach x-ray was normal. Colon x-ray revealed conglomeration of large and small bowel in the region of the cecum, believed due to adhesions. He had occult blood in the stools, a normal hemogram, increased direct reacting serum bilirubin, and normal thymol and cephalin cholesterol flocculation tests. Needle biopsy was performed. The report was "metastatic anaplastic carcinoma" (Fig. 3). The clinical course was rapidly downhill and the patient died in coma. Autopsy revealed a small anaplastic carcinoma of the sigmoid with extensive metastases. The roentgenologist reported that dense intestinal adhesions were also present, but they were unrelated to the neoplasm.

Comment. It is of interest that when the x-rays were reviewed with the roentgenologist, the lesion could still not be detected even though its site was known.

CASE 6—W. S., a 60 year old white female, was in good health until a year preceding hospitalization. She entered the hospital in 1951 because of a 25 pound weight loss, pain in the right upper quadrant, fat intolerance, and episodes of nausea and vomiting. Jaundice was noted six weeks before admission. The history was negative for alcoholism, dietary deficiency, and hepatotoxins. She was

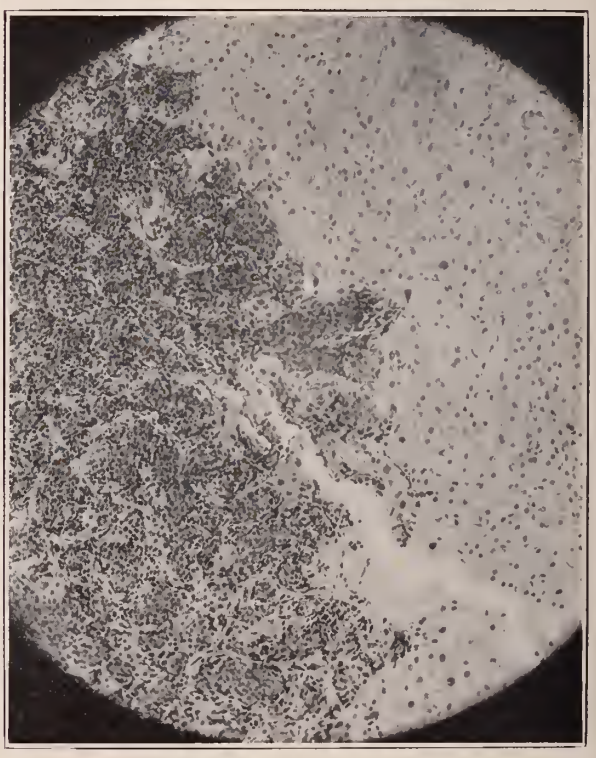


Fig. 3—Metastatic anaplastic carcinoma in the liver. The liver cells on the right are not remarkable.

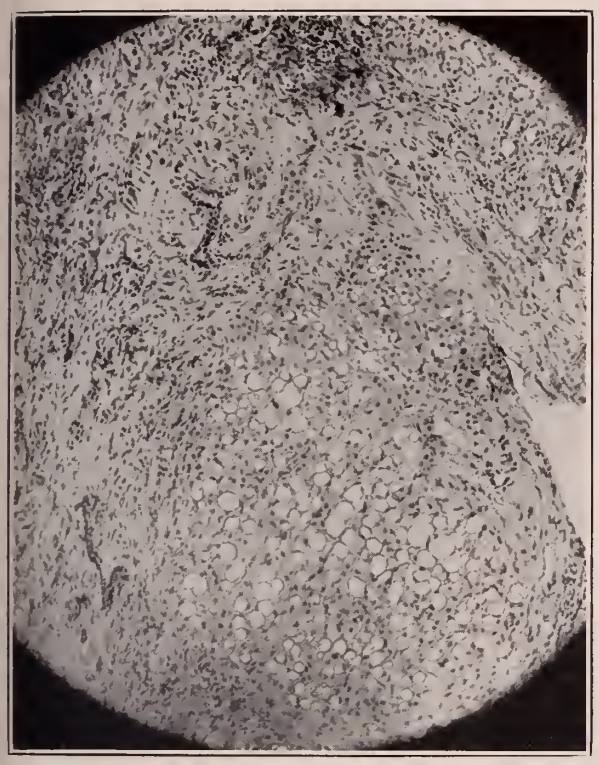


Fig. 4—Diffuse nodular Laennec's cirrhosis. Note complete distortion of lobular architecture, fibrosis, and proliferating bile ducts. The liver cells show marked lipoid vacuolization.

slightly icteric and emaciated and had ascites, prominent superficial abdominal veins, and hepatomegaly. The liver was firm and nodular. There was a severe hypochromic anemia, increased direct reacting serum bilirubin, increased urinary urobilinogen, and a sharp decrease in the cholesterol ester. Liver biopsy was performed after ascitic fluid had been removed, and was interpreted as showing diffuse nodular Laennec's cirrhosis (Fig. 4). With treatment, she showed some improvement and was discharged. Within a month, however, she required paracentesis, and three months later she died at home.

Case 7—H. R., an 89 year old white male, entered the hospital in 1951 because of pain in the right upper quadrant, nausea and vomiting, weight loss, and marked weakness for two months. Two years before, he had had a resection of his prostate gland for adenocarcinoma. Jaundice; hepatomegaly; elevated serum bilirubin, both direct and indirect components; increased urinary urobilinogen; and a normal hemogram were noted. Liver biopsy resulted in the interpretation of "parenchymatous degeneration and mild fatty metamorphosis." With dietary supplements the jaundice cleared up completely, and the patient showed sufficient improvement to return home in June 1951. He died at another hospital almost a year later. Autopsy revealed the cause of death to be extensive pulmonary metastases from the prostatic carcinoma. The liver was finely granular and normal in size. Microscopically it showed fatty metamorphosis and round cell infiltration of the portal areas.

Comment. Liver biopsy was performed because of the clinical suspicion of metastatic disease. In this instance it furnished a true picture of the liver disease. Biopsy may give a positive diagnosis if the needle happens to strike neoplastic tissue, but a negative report does not necessarily exclude malignancy.

Case 8—A. S., a 71 year old white female, was hospitalized in 1951 because of lack of energy and polyuria for three months. Her appetite was good and she had been gaining weight. She was obese and her liver was enlarged. X-rays of the gallbladder, stomach, large bowel, and chest were normal. The serum bilirubin, albumin, and globulin were normal. Total cholesterol was 245 mg., and esters measured 158 mg. Thymol turbidity

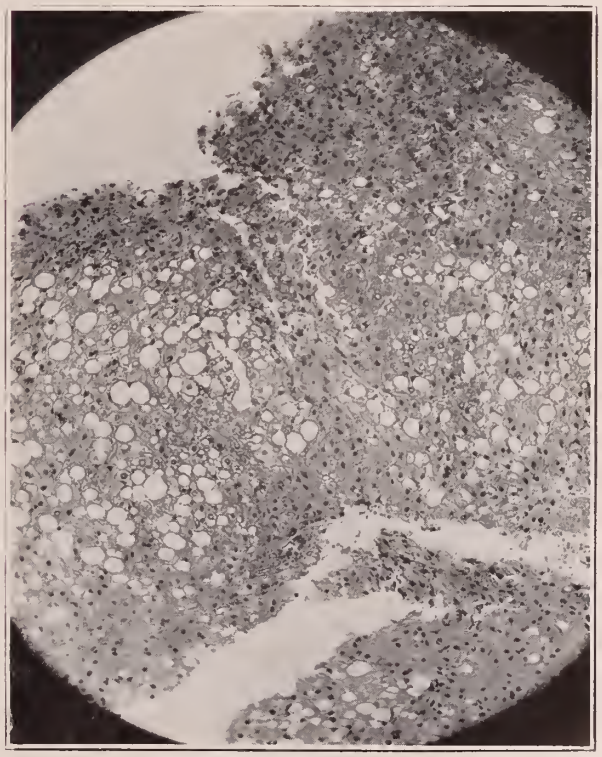


Fig. 5—Fatty metamorphosis. Note normal lobular architecture.

was 8 units, and flocculation 3 plus. The Exton-Rose glucose tolerance test gave a diabetic curve. Liver biopsy was done to determine the cause of the hepatomegaly. The pathologic report was fatty metamorphosis (Fig. 5). Lipotropic agents and a reducing diet were prescribed. Follow-up a year later has shown an excellent clinical response. Weight reduction was satisfactory, the liver was no longer palpable, and the urine was consistently free of sugar.

CASE 9—A. C., a 72 year old white male, a mild diabetic, entered the hospital in April 1952 because of epigastric pain after meals and with excitement for six months. He gave a history of moderate wine drinking. A diagnosis of arteriosclerotic heart disease was made, but because of the finding of an enlarged liver and laboratory evidence of liver dysfunction (icterus index of 9.3 units and a 2 plus cephalin cholesterol flocculation) needle biopsy was performed. The pathologic interpretation was early Laennec's cirrhosis. He returned home and a follow-up report from his physician stated that he died suddenly two days later, probably from a myocardial infarct.

CASE 10—L. H., a 52 year old white male tavern keeper, was hospitalized in May 1952 because of nausea, vomiting, and abdominal distention for one week. He gave a history of heavy drinking. He was obese and had an enlarged liver and hemorrhoids. Increased urinary urobilinogen, hypochromic anemia, normal serum bilirubin, and negative cephalin cholesterol flocculation test were noted. Liver biopsy revealed "overwhelming fatty metamorphosis and moderate thickening of the fibrous trabeculi." The interpretation was an early Laennec's cirrhosis. He was placed on the usual therapeutic management and discharged.

Comment. Liver biopsy in this case not only established the diagnosis but furnished information of prognostic value. Because of the fatty liver and only moderate connective tissue proliferation with preservation of normal liver architecture, it was felt that a good therapeutic response was possible.

CASE 11—E. G., a 63 year old white male, was hospitalized in January 1952 because of easy fatigability, weight loss, and abdominal distention of two months' duration. He had ascites and was emaciated. The liver was not palpable, no abdominal masses were felt, and rectal examination was negative on initial examination. The patient had extensive laboratory and x-ray studies, with the positive findings only of a hypochromic anemia, 2 plus thymol flocculation, and hyperglobulinemia with reversal of the albumin-globulin ratio. Paracentesis yielded 6 liters of greenish fluid which was negative for neoplastic cells. The patient was a diagnostic problem. Because of the laboratory evidence of hepatic dysfunction, liver biopsy was done through an intercostal approach. The pathologic interpretation was an advanced fatty metamorphosis. It was felt that this was not sufficient to explain his symptoms. Observation over a period of time disclosed a rapidly enlarging mass in the left upper and middle abdomen, which apparently was spleen. A second rectal examination revealed the appearance of a hard ridge of tissue above the prostate. He then left the hospital and was examined at a large medical center in the Midwest, where the previous findings were corroborated and a clinical diagnosis of carcinomatosis was made. Roentgen therapy was given to the abdomen. He was last seen in July 1952, at which time the spleen was smaller and he showed clinical improvement.

Comment. He apparently had a radiosensitive neoplasm. An exact diagnosis was not made. Needle biopsy in this case did not aid in the diagnosis.

CASE 12— M.H., a 34 year old white male, was hospitalized in September 1952 because of weight loss, anorexia, gradual decline in strength for six months, and abdominal distention for two weeks. He gave a history of chronic alcoholism. He had ascites, hemorrhoids, dilated abdominal veins, slight icterus, proteinuria, a macrocytic anemia, reversal of the albumin-globulin ratio, reduction in cholesterol ester, 4 plus thymol flocculation, and elevation of both components of the serum bilirubin. Ascitic fluid was removed and reported negative for neoplastic cells. The excretory urogram and stomach x-ray were normal. A clinical diagnosis of cirrhosis was made. Because the liver was not palpable, needle biopsy was done through an intercostal approach. The pathologic interpretation was diffuse nodular Laennec's cirrhosis. The patient left the hospital and a follow-up report from his physician stated that paracentesis was frequently necessary and the clinical course was rapidly downhill.

Comment. Liver biopsy confirmed the clinical impression in this case and also was of

prognostic value, since the advanced process seen in the liver foreshadowed the poor therapeutic response.

Discussion

With careful selection of patients, based primarily on normal prothrombin, bleeding, and coagulation time determinations, no untoward reactions occurred in any of this small series of cases. Of the 10 patients with hepatomegaly, needle biopsy revealed primary hepatic carcinoma in 1, Laennec's cirrhosis in 4, metastatic carcinoma in 3, fatty metamorphosis and parenchymatous degeneration in 1, and fatty metamorphosis in 1. Of the 2 cases without hepatomegaly, needle biopsy revealed fatty metamorphosis in 1 (case 11) but gave no clue to the fundamental disease process, and revealed advanced Laennec's cirrhosis in case 12. Schiff,[2] in a larger series, has demonstrated the value of liver biopsy in such conditions as obstructive jaundice, viral hepatitis, sarcoidosis, hemochromatosis, tuberculous granuloma, Hodgkin's disease, and leukemic infiltration of the liver.

In this small and carefully selected series, needle biopsy of the liver was a safe and valuable procedure which greatly aided clinical management and spared the patients unnecessary surgery.

---

419 Main Street.

REFERENCES

1. Cogswell, R. C., and others: Needle biopsy of the liver, J.A.M.A. 140:385–390 (May 28) 1949.
2. Schiff, L.: The clinical value of needle biopsy of the liver, Ann. Int. Med. 34:948–967 (April) 1951.

MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have graduated from medical school within the past ten years and are residing in the state of Wisconsin or are in the Armed Forces at the time the essay is submitted. Physicians who graduated from medical school more than ten years ago may submit essays if deduction of their period of service in the Armed Forces will bring them within the above-mentioned ten year period after graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial contest, for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, though not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be double spaced and submitted in triplicate to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

High Intestinal Obstruction in the Newborn*

By JOHN ERBES, M. D., F. A. C. S.**
Milwaukee

CONSIDERABLE progress has been made in pediatric surgery during the past few years. A good portion of this has been in the surgical correction of congenital anomalies. Comparable progress and reduction in mortality has not, however, been achieved in the treatment of high intestinal obstruction in the newborn. This condition is thought to be due to a number of reasons, including associated anomalies, prematurity, the acuteness of the condition and the urgency for immediate treatment, failure to understand the basic cause of the obstruction, and pneumonitis associated with aspiration of the vomitus. I would like to review the cases seen at Milwaukee Children's Hospital in the past 25 years.

High intestinal obstruction in the newborn is caused by two types of lesions:

1. Intrinsic, due to atresia or stenosis of the bowel itself.
2. Extrinsic, due to some lesion outside the bowel, pressing against the bowel and obstructing the lumen. This kind of lesion consists of a constricting band and twisting of the bowel found in malrotation of the intestines with midgut volvulus.

Congenital Stenosis and Atresia

In the past 25 years there have been 13 cases of congenital stenosis and 12 cases of congenital atresia treated surgically at Milwaukee Children's Hospital. Of the 13 patients with stenosis, 9 recovered and 4 died. Of the 12 patients with atresia, 4 recovered and 8 died.

Since the symptomatology, etiology, and treatment of these two conditions is similar, they will be considered together.

Symptoms. Vomiting was the most important symptom. It was found in all of our cases. The vomitus was reported to be bile stained in two thirds or more of the cases of duodenal, jejunal, and ileal lesions. The vomiting was reported to be projectile in less than one third of the cases of duodenal obstruction. Fecal vomiting was reported in one half of the cases with ileal lesions and in none of the cases with jejunal lesions.

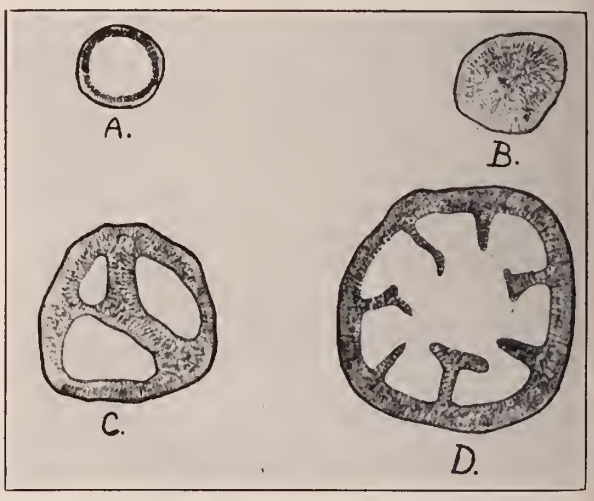


Fig. 1—(A) Epithelial lined intestinal tube prior to the fifth week of fetal life. (B) Epithelial proliferation obliterating intestinal lumen between the fifth and eighth week of fetal life. (C) Isolated pockets begin to form in the proliferated epithelium at the eighth week of fetal life. (D) Coalescence of the pockets re-establishes the intestinal lumen by the twelfth week of fetal life.

Loss of weight, obstipation, and dehydration were present in the majority of cases. Abdominal distention was most pronounced in the low lesions of ileal and cecal obstruction.

Pathology. Two types of lesions are found in intestinal atresia. The most common variety is a complete discontinuity of the bowel, with the ends as blind sacs. Or there may be an internal diaphragm. When the diaphragm is incomplete, the condition is known as a stenosis.

Etiology. In order to understand the origin of the underlying cause of the obstruction, it is necessary to follow the embryologic development of the intestine through its various stages.

Before the fifth week of fetal life, the lumen of the intestine is lined with epithelium. At about the fifth week the epithelium proliferates and obliterates the lumen from the pylorus to the ileocecal valve. Around the eighth week isolated pockets form in the

* Presented before the Wisconsin Surgical Society, Milwaukee, September 13, 1952.

** From the Surgical Service of Milwaukee Children's Hospital, Milwaukee.

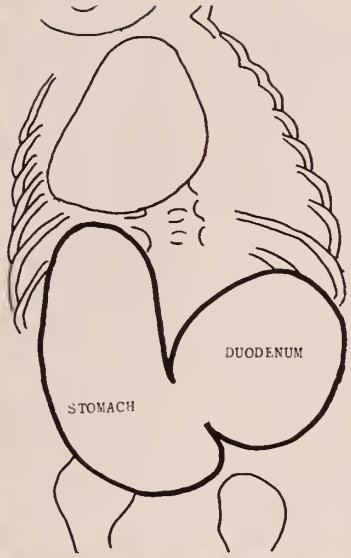
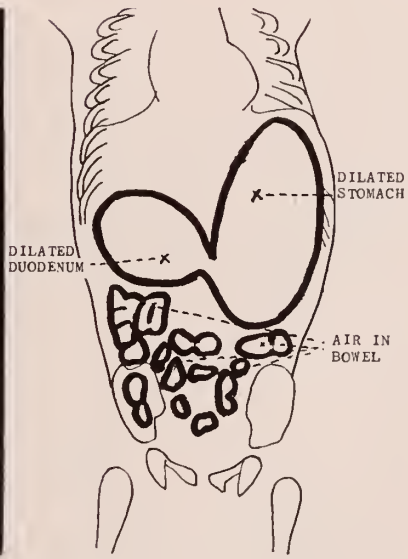


Fig. 2—Atresia of the duodenum showing the dilated stomach and duodenum on the flat plate of the abdomen. This patient also had a dextrocardia and a complete situs inversus of all of the viscera. There are no gas shadows in the remaining intestines.

Fig. 3—Atresia of the duodenum with a previous gastroenterostomy done shortly after birth. The patient continued to vomit. Flat plate of the abdomen revealed a dilated stomach and duodenum with gas shadows in the remaining large and small intestines. A duodenojejunostomy was done to prevent collection of food and gas in the blind duodenal sac.



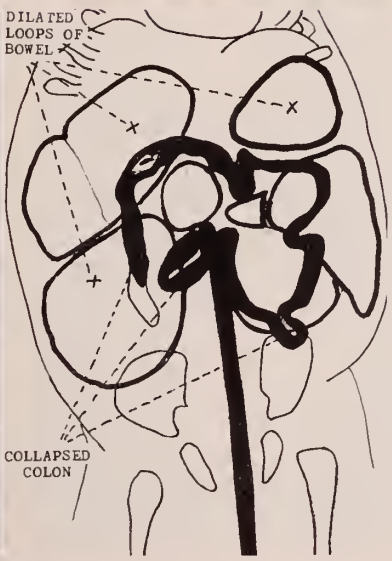


Fig. 4—Atresia of the jejunum showing the markedly dilated loops of small intestines. Barium enema reveals the string-like lumen of the large intestine which has not been dilated as the large intestine of the normal newborn infant has by intrauterine swallowing of amniotic fluid.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

mass of proliferated epithelium. A coalescence of the spaces re-establishes the intestinal lumen by the twelfth week. Failure of the spaces to coalesce may result in an atresia or a stenosis.

Diagnosis. The diagnosis is made from a history of vomiting, loss of weight, obstipation, and x-ray studies. Considerable information can be obtained from a scout film of the abdomen. The so-called "double stomach" will be evident in cases of duodenal obstruction, one shadow being the stomach filled with air and the second shadow being the markedly dilated duodenum filled with air. In a duodenal atresia there will be no evidence of air in the remaining small or large intestines. In duodenal stenosis there may or may not be x-ray evidence of air in the remaining bowel. Frequently this alone is sufficient to make a diagnosis and suggest that an operation be performed immediately.

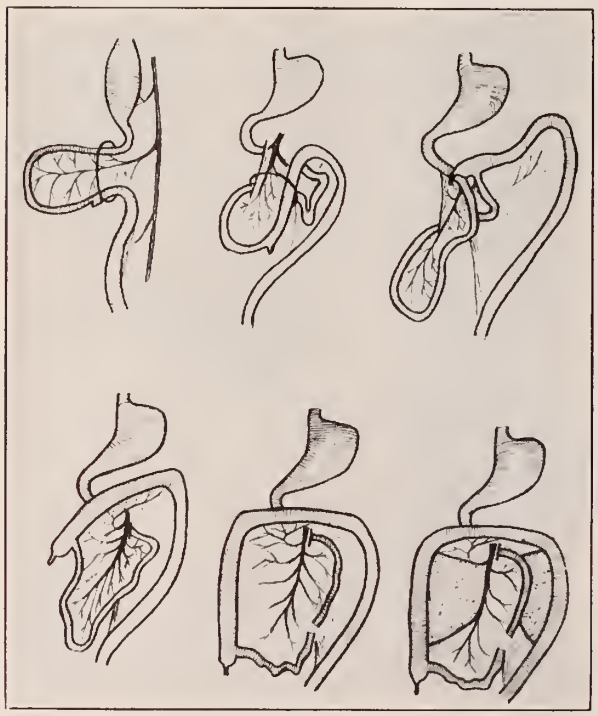


Fig. 5—Normal rotation of the fetal intestines. (Redrawn from Ladd and Gross[6]). Top, left to right: (A & B) Since intestines grow faster than the celomic cavity between the fifth and tenth week of fetal life, part of the intestines herniate into the umbilical cord. (C) After the tenth week the peritoneal cavity grows faster than the intestines and they are withdrawn into the abdominal cavity again.

Bottom, left to right: (D) The bowel begins to rotate in a counterclockwise direction around its mesenteric attachment so that the cecum reaches the right upper quadrant of the abdomen at the eleventh week of fetal life. (E) Rotation is complete when the cecum reaches the right lower quadrant. (F) The mesenteries of the ascending and descending colon fuse with the peritoneum of the posterior abdominal cavity wall resulting in the so-called retroperitonealization of the ascending and descending colon.

In jejunal and ileal lesions the small bowel may be markedly dilated, with the loops of the bowel containing air over a fluid level when the x-ray is taken in the upright or head-down position. Barium is frequently unnecessary and is considered to be not without danger because of the possibility of aspiration during vomiting. When it is used, it should be a small amount and a thin mixture. It should also be removed after x-ray by gastric lavage. Some prefer to use Lipiodal.

Barium enema will reveal a thin string-like colon in an atresia. If there is considerable distention, a barium enema should not be given.

Treatment. Treatment is surgical. Considerable preoperative care is often necessary, but this should be done quickly in order not to lose valuable time.

Gastric suction is necessary to prevent vomiting and possible aspiration.

Subcutaneous or intravenous fluids are given to relieve dehydration and electrolyte imbalance.

Blood transfusion through a cut down in the ankle vein (long saphenous) is usually given preoperatively or during surgery.

Operation. Gastroenterostomy or duodenojejunostomy are the operations of choice for duodenal lesions, depending on the site of the obstruction. Duodenojejunostomy is preferable in lesions of the third portion of the duodenum, especially in cases of atresia. We have had to reoperate cases in which gastroenterostomy was done and do a duodenojejunostomy because of persistent vomiting due to the blind pouch in the duodenum.

Entero-anastomosis is done in jejunal and ileal lesions.

Ileostomy is to be condemned as treatment in this condition. There are no cases in our series and few among those reported in the literature in which treatment by ileostomy has been successful. The procedure leads to extreme dehydration and an electrolyte imbalance which infants tolerate very poorly.

Dilatation of a stenotic area or cutting through a diaphragm type of obstruction is usually very unsatisfactory and time consuming and is contraindicated. It is usually easier and safer to detour around such an obstruction with a side to side anastomosis.

Anastomosis is frequently difficult in atresia because of the small distal segment which has never been dilated. It can be made easier

by injecting saline or oil into the distal bowel lumen to dilate the bowel. This procedure will also help determine whether there are other sites of obstruction beyond that point, since not infrequently there are multiple anomalies. It was necessary to re-operate one of our cases of jejunal atresia when a second lesion was found about two feet farther down.

Autopsy material available on those who died shows that the majority died of aspiration pneumonia.

Malrotation of the Intestine

Twenty-four cases of malrotation of the intestine have been seen at Milwaukee Children's Hospital in the past 25 years. Twelve of these patients recovered and 12 died. All but 3 of those who recovered were treated surgically. Those 3 were found inadvertently to have malrotation of the intestine during surgery for another cause, or during x-ray studies. Of those that died, only 4 were treated surgically. Six of these patients had accompanying multiple congenital anomalies not compatible with life. Pneumonia developed in 2 others and they died before surgery could be attempted. Two of those treated surgically died of aspiration pneumonia, 1 died of peritonitis due to preoperative bowel gangrene and perforation, and the other was a premature infant who died postoperatively.

Etiology. As in the intrinsic type of obstruction, the cause of the extrinsic type of obstruction is best understood by following

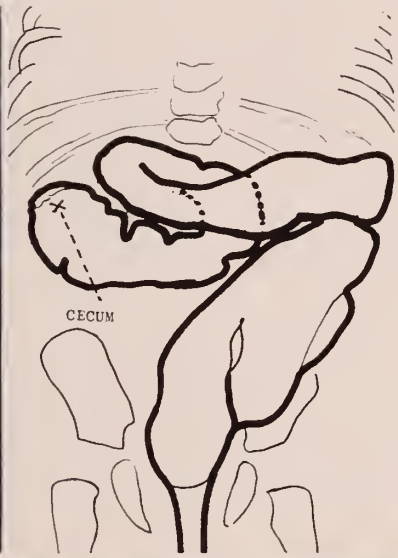


Fig. 6—Malrotation. Barium enema reveals that the cecum has been halted in its rotation in the right upper quadrant.

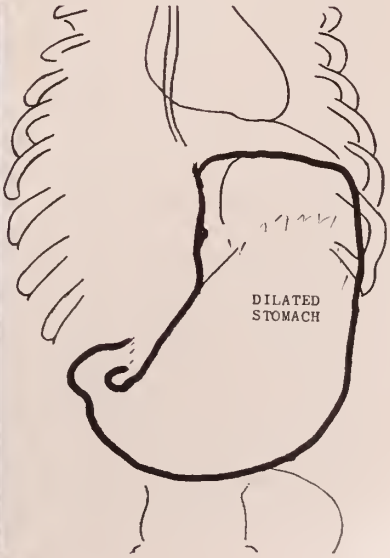


Fig. 7—Malrotation showing barium-filled and markedly dilated stomach and obstruction at the duodenum.

the embryologic development of the intestines.

At about the tenth week of fetal life, the large intestines begin to grow in length faster than the length of the abdominal cavity will accommodate. Since the bowel is attached to the posterior abdominal wall by its mesentery, it rotates around its mesenteric attachment as it grows, so that the cecum rotates in a counterclockwise direction. At about the eleventh week, the cecum has reached the right upper quadrant. Shortly thereafter, rotation is complete as the cecum descends into the right lower abdomen and the mesenteries of the ascending and descending colon fuse with the posterior peritoneum to make these sections of the large bowel retroperitoneal. Most cases of malrotation are a result of the interruption of rotation at the eleventh fetal week. There is usually a peritoneal band attaching the cecum to the posterior peritoneum in the right upper abdomen. This band apparently is associated with the interruption of the normal rotation process and probably prevents the cecum from descending into the right lower quadrant and prevents subsequent fusion of the ascending and descending mesocolon to the posterior peritoneum. Frequently this band is tight enough to cause duodenal obstruction at the site where it crosses over the descending portion of the duodenum.

Pathology. The pathology is usually due to two separate conditions: first, the constriction of the duodenum by the peritoneal band, or Ladd's band; second, volvulus of the midgut around the loose unattached mesentery. This volvulus results in intestinal obstruction of the bowel which has twisted itself around its pedicle of mesentery containing the blood vessels to the bowel. If the volvulus should be tight enough to cause vascular occlusion to the bowel involved, gangrene and perforation of the intestine may result. This happened in one of our cases.

Diagnosis. The diagnosis is made by a history of vomiting and by x-ray studies. A flat plate x-ray of the abdomen usually reveals a distended stomach, duodenal obstruction, and in about one half of the cases a small amount of gas in the remaining intestines.

Barium by mouth reveals duodenal obstruction. After a few minutes a little of the barium may be seen in the small bowel.

Barium enema is usually diagnostic. It reveals the cecum in the right upper quadrant, showing a partial rotation of the large bowel.

Treatment. It is not necessary to differentiate preoperatively between congenital stenosis or atresia of the small intestine and malrotation with midgut volvulus. It is necessary only to make a diagnosis of bowel obstruction. Surgery is indicated in all of these conditions.

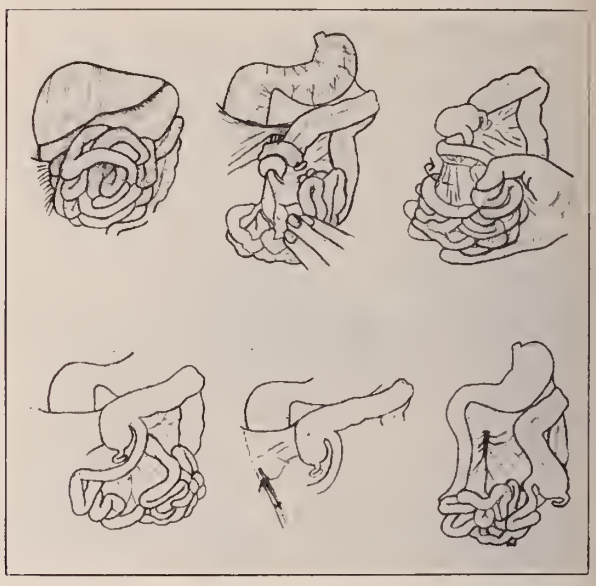


Fig. 8—(Redrawn from Ladd and Gross[6]). Top, left to right: (A) The appearance of the viscera when the abdomen is just opened. The small bowel is seen as a ball-like mass of intestines. The dilated stomach is evident, but the transverse colon cannot be seen in its usual position. (B) When the mass of small intestines is lifted out of the abdominal cavity the volvulus of the midgut can be seen with the intestines twisted around the mesenteric pedicle. (C) The volvulus is reduced by untwisting the bowel in a counterclockwise direction.

Bottom, left to right: (D) Fibrous bands extending from the cecum to the posterior peritoneal wall of the right upper abdomen cross over the duodenum, causing duodenal obstructions. (E) The duodenal obstruction is relieved by cutting the fibrous bands. (F) After the bands are cut, the cecum and ascending colon are allowed to fall to the left side of the abdomen.

The treatment of midgut volvulus and malrotation is directed at two separate lesions. First, the twisted bowel of the midgut volvulus is derotated by lifting all of the intestines out of the abdomen for proper inspection. It is impossible to evaluate the condition and to do the derotation with the intestines inside the abdominal cavity. The bowel is untwisted in a counterclockwise direction. Second, the peritoneal band that extends from the cecum to the posterior peritoneum is cut. This band extends across the duodenum and causes duodenal obstruction.

Cutting the band allows the cecum and ascending colon to fall to the left side of the abdomen where they should be allowed to remain. Any attempt to fasten them down may lead to disaster.

Cutting of this band is frequently neglected or not understood and necessitates reoperation, since the duodenal obstruction is not relieved.

One of our patients was operated on three times for this condition. The first two operations were done elsewhere. The patient died after the third operation.

Three of our patients required gastroenterostomy in addition to derotation and cutting of the constricting band. One had an aplastic type of duodenal atresia and the other 2 had duodenal stenoses at the site of the band. The duodenal lumen was thought to be inadequate even though the band was cut.

Several of our early cases were treated with gastroenterostomies around the constricting bands after derotation instead of cutting the constricting bands.

324 East Wisconsin Avenue.

REFERENCES

1. Arnheim, E. E.: Congenital ileal atresia with gangrene, perforation and peritonitis in a newborn infant, Am. J. Dis. Child. 69:108–116 (Feb.) 1945.
2. Benson, C. D., and Coury, J. J., Jr.: Congenital intrinsic obstruction of the stomach and duodenum in the newborn, Harper Hosp. Bull., Detroit, 10:1–4 (Jan.–Feb.) 1952.
3. Jones, T. B., and Morton, J. J.: Congenital malformations of the intestines in children, Am. J. Surg. 39:382–399 (Feb.) 1938.
4. Judd, E. S., and White, R. B.: Congenital anomalies of the duodenum with obstruction at the duodenojejunal angle, Ann. Surg. 89:1–5 (Jan.) 1929.
5. Kittrell, B. M., Callaway, L., and Curtis, L. F.: Congenital atresia of the intestine in a premature infant, J. Pediat. 35:772–775 (Dec.) 1949.
6. Ladd, W. E., and Gross, R. E.: Abdominal Surgery of Infancy and Childhood, Philadelphia, W. B. Saunders Company, 1948, pp. 25–70.
7. McIntosh, R., and Donovan, E. J.: Disturbances of rotation of the intestinal tract, Am. J. Dis. Child. 57:116–166 (Jan.) 1939.
8. Miller, E. M., Greengard, J., Raycraft, W. B., and McFadden, I.: Congenital atresia of the duodenum and of the ileum, Am. J. Dis. Child. 66: 272–279 (Sept.) 1943.
9. Haymond, H. E., and Dragstedt, L. R.: Anomalies of intestinal rotation, Surg., Gynec. & Obst. 53: 316–329 (Sept.) 1931.
10. Spencer, R.: Intestinal obstruction in the newborn associated with faulty development of the midgut and its mesentery, Surg., Gynec. & Obst. 95: 568–578, (Nov.) 1952.
11. Wakefield, E. G., and Mayo, C. W.: Intestinal obstruction produced by mesenteric bands in association with failure of intestinal rotation, Arch. Surg. 33:47–67 (July) 1936.

TABLE 1—*Symptomatology*

	Vomiting	Bile in Vomitus	Fecal Vomiting
Duodenal Stenosis	100%	66%	0
Duodenal Atresia	100%	66%	0
Malrotation	75%	17%	0
Jejunal Lesions	100%	60%	0
Ileal Lesions	100%	73%	50%

TABLE 2—*Stenosis: Results of Operative Treatment*

Site of Stenosis	Operation	Results	
		Deaths (4)	Recoveries (9)
Duoduimn (10 cases)	Gastroenterostomy	(2) 1943 1946	(5) 1935 1949 1940 1949 1944
	Duodenojejunostomy	(1) 1951	(2) 1949 1952
Jejunum (1 case)	Entero-anastomosis	(0)	(1) 1943
Ileum		(0)	(0)
Ileocecal (2 cases)	Dilatation of Stenosis	(1) 1929	(0) 1952
	Ileocecostomy	(0)	(1)

TABLE 3—*Atresia: Results of Operative Treatment*

Site of Atresia	Operation	Results	
		Deaths (8)	Recoveries (4)
Duodenum (4 cases)	Gastroenterostomy	(1) 1945	(1) 1949
	Duodenojejunostomy	(1) 1952	(1) 1952
Jejunum (3 cases)	Entero-anastomosis	(2) 1927 1943	(1) 1952
Ileum (4 cases)	Entero-anastomosis	(2) 1933 1950	(1) 1951
	Ileostomy	(1) 1937	(0)
Ileocecal (1 case)	Ileocecostomy	(1) 1947	(0)

TABLE 4—*Malrotation*

Age Distribution			
Age	No.	Died	Recovered
1 Week	8	5	3
3 Weeks	2	0	2
4 Weeks	6	3	3
6 Weeks	1	1	0
2 Months	1	1	0
3 Months	1	1	0
6 Months	1	1	0
1 Year	1	0	1
2 Years	1	0	1
3 Years	1	0	1
9 Years	1	0	1
TOTALS	24	12	12

(Tables continued on next page)

TABLE 5—*Malrotation Recoveries* (12)

Age	No.	Year	Operation	Remarks
1 Week	3	1949	Gastroenterostomy and derotation	
		1951	Entero-enterostomy, derotation, and cut bands	
		1951	Derotation and cut bands	
3 Weeks	2	1927	Derotation and cut bands	
		1951	Duodenojejunostomy	Also had an atresia Gastroenterostomy done elsewhere first
4 Weeks	3	1946		Found during pyloromyotomy
		1949	Derotation only	
		1952	Cutting of bands	
1 Year	1	1951		Found on x-ray
2 Years	1	1949	Gastroenterostomy, derotation, and cut bands	
3 Years	1	1933	Derotation only	
9 Years	1	1945		Found during appendectomy

TABLE 6—*Malrotation Mortality* (12)

Age	Died	Year	Operation	Cause of Death
1 Week	5	1940	Gastroenterostomy	Peritonitis from pre-op. bowel perforation
		1947		Multiple anomalies including tracheo-esoph. fistula
		1948		Multiple anomalies Heart incompatible with life
		1951	Derotation and cut bands	Aspiration pneumonia, subdural hematoma, birth injury
		1952		Multiple anomalies
4 Weeks	3	1949	Gastroenterostomy (two previous operations done elsewhere)	Pneumonia
		1952		Multiple anomalies
		1952		Multiple anomalies Heart incompatible with life
6 Weeks	1	1927		Multiple anomalies
2 Months	1	1928	Derotation only	Prematurity
3 Months	1	1927		Pneumonia
6 Months	1	1934		Pneumonia

TB SYMPOSIUM FOR GP'S IN SARANAC LAKE THIS SUMMER

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, New York, from July 13 through July 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for members of the American Academy of General Practice and $50 for non-members. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

These symposia are the result of many requests from general practitioners for a postgraduate course on pulmonary tuberculosis designed for them and presented over a period short enough so that they might readily attend. The 1953 symposium has been planned to meet those needs and to cover all important aspects of pulmonary tuberculosis from the general practitioner's point of view.

Many of the sessions are informal panel discussions with ample opportunities for questions from the audience.

The symposium will be held in various sanatoria and laboratories in the Saranac Lake area. Morning sessions will be from 8:30 to 12:30 and afternoon sessions from 2:00 to 3:30 (Monday, Wednesday, and Thursday). There will be elective sessions on Tuesday and Friday afternoons. Physicians desiring to make patient rounds will have that opportunity each afternoon at 4:00. On Monday, July 13, there will be a dinner for physicians attending the course, their families, and the faculty.

The speakers and panel members at the tuberculosis symposium will include physicians, surgeons, and scientists from Saranac Lake and surrounding areas.

Complete information concerning this program can be obtained by writing Richard P. Bellaire, M. D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

Surgery of Carcinoma of the Rectosigmoid in Selected Cases

By H. B. BENJAMIN, M. D. and MARVIN WAGNER, M. D.*
Milwaukee

WHEN there is no lymphatic invasion, cancer of the rectum is surgically curable in the great majority of cases, no matter what operative procedure is chosen. If metastasis occurs in the lymph nodes, the incidence of favorable results is reduced to approximately 20 per cent and may even be reduced to zero. In the presence of lymph gland metastasis, the more radical surgery offers no greater hope than the most conservative method.

Unless adequate therapy is instituted, carcinoma of the rectosigmoidal area is inevitably fatal. The introduction of the combined abdominal perineal resection for carcinoma of the rectosigmoid was a step toward proper approach to this surgical problem. The stress placed on the surgeon by the pathologist to be as radical as possible has driven the somewhat conservative surgeon to attempt the extremes. The pathologist has not extended his sphere of influence to the patient who wishes conservative treatment. In surgery, the patient must be a good physical as well as mental risk, for it is of supreme importance that the patient who elects to have a colostomy must have the ability to adjust himself mentally as well as physically to the drastic revision in his daily life. Because of this problem, the operation for carcinoma of the sigmoid rectum should be tailored to the individual. To what avail is a good surgical extirpation of the sigmoid rectum with a permanent colostomy if the patient does not have the will to live with the end result of this type of radical surgery?

Gilchrist states that the main objective is to remove the cancer, along with radical resection of the regional lymphatics. After this is done, continuity is established whenever possible.[7] J. W. Baker has found the use of a low end to side rectosigmoidal anastomosis to be more than adequate in sigmoidal or rectosigmoidal lesions with distant nonresectable metastasis. In cases in which a frank palliative resection is to be carried out, reestablishment of bowel continuity is essential. In these cases, the preservation of normal anal function is desirable and adds greatly to both physical and mental comfort of the patient. We have adopted this method in just such cases, and also in secondary malignant changes in stalk polypi, where the stalk shows no abnormal microscopic cell structure.

Method

In any type of intestinal anastomosis, when reasonable care is used, the fatal angles are the weak links in the procedure. The disparity in the caliber of the segments of the intestine in an end to end anastomosis between the descending colon and rectal ampulla presents an added hazard. The number of fatal angles increases in direct relationship to the difference in size between the two segments of bowel to be anastomosed. The more crimping or tucking necessary, the greater the number of fatal angles. In a side to end anastomosis, the lumen of one segment is adjusted to the lumen of the other without crimping.

The abdomen is opened by a low midline incision. The abdominal cavity is explored for metastasis. The size of the tumor is evaluated, and if it is possible to do a wide resection and still retain 1½ to 2 inches of the rectal ampulla, a side to end anastomosis is performed. The operation starts as though a Miles' operation were to be done. The rectosigmoid and rectal ampulla, including the tumor, are removed. The peritoneal reflections are prepared. The superior hemorrhoidal artery is ligated and the lateral ligaments of the rectum are cut. All lymph glands are removed, as in the Miles' procedure. The distal end of the descending colon is then cut at an angle on the anti-mesenteric side to fit the rectal stump. The descending colon is then approximated to the rectal stump. After the lateral gutter is split up to the splenic flexure, the splenic flexure is mobilized. The descending colon is now

* Department of Anatomy, Marquette University School of Medicine.

moved into place and the rectal stump is tacked to the descending colon by stay sutures. The posterior row of sutures is placed with extreme care and the new ostium in the descending colon is completed. Because of the previous preparation of the intestine with sulfonamide and antibiotics, and because a better approximation can be made, the open method of anastomosis is used. We use no crushing clamps and have found no need for drains.

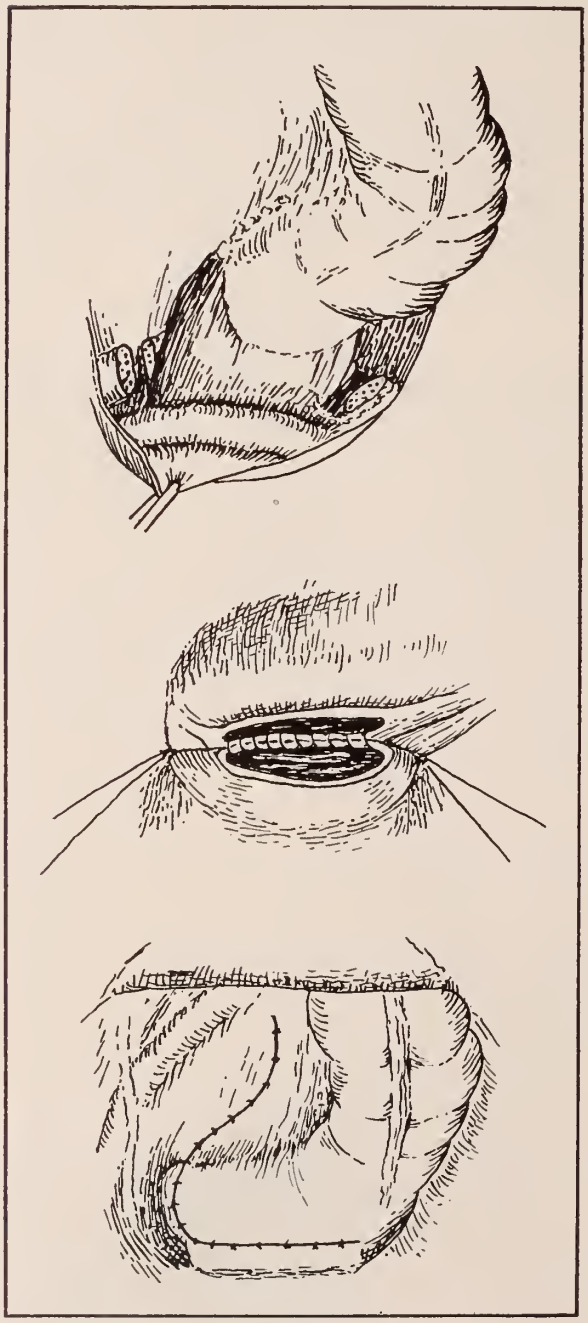


Fig. 1—Top to bottom: (A) The sigmoid and rectum are freed and the rectal ligaments have been severed. (B) The side to end junction is made without clamps by use of stay sutures. (C) The anastomosis completed, and the peritoneal reflections tacked to the suture line.

In preparing for a side to end anastomosis we have found it advisable to do a preliminary colostomy in all patients as a prophylactic measure for decompression of the bowel, which obviates the tension on the suture line and consequent blow-outs. The preoperative preparation begins in the hospital three days before surgery. The patient is given daily tap water enemas in the knee-chest position. To reduce the bacterial flora a combination of Aureomycin and Sulfathalidine is administered. A laboratory survey of the patient is taken to determine whether his total protein and electrolyte balance and hemogram are satisfactory.

The postoperative care of the patient is routine. Morphine sulfate is given for pain, as needed, for the first 24 hours. If necessary, whole blood is given to prevent and combat shock. Water and electrolyte balance is maintained by giving all necessary fluids by mouth whenever possible. Wangensteen suction is used only if necessary, to prevent distention, but a rectal tube is used routinely to relieve the suture line of gas pressure. The rectal tube is covered with gauze saturated with Nupercainal ointment.

The following three cases epitomize the results we have obtained in this type of surgery.

M. S. entered the hospital on April 30, 1952. The entrance diagnosis was carcinoma of the rectum. A biopsy, previously performed, showed the malignancy to be an adenocarcinoma, grade II. Her entrance complaint had been diarrhea since June 1951. After a resection on May 12, 1952, the report on the tissue was again adenocarcinoma, grade II. The patient was dismissed on May 20, 1952. Her highest temperature was 99.8 F. On Dec. 9, 1952, the patient re-entered the hospital because of some bleeding and a stricture. The stricture at the suture line was dilated and a polyp was removed. The pathologic report on this tissue was granulation tissue, no malignancy.

M. R. entered the hospital on Feb. 18, 1952. Three weeks before, he had had four episodes of rectal bleeding in a two day period. The patient had been under a doctor's care for colitis for the last eight years, and during that time had had numerous bouts of diarrhea. He had lost 14 pounds in the last year.

Fig. 2—Preoperative barium enema study showing size and location of the carcinoma.

On March 11, 1952, the patient left the hospital with a diagnosis of carcinoma of the rectum. The pathologic report on the specimen was mucoid adenocarcinoma, grade III. A side to end sliding anastomosis was performed. Except for a temperature of 103.4 F. for a period of three days, the patient made an uneventful recovery.

M. H. went to her family doctor because of gross rectal bleeding. She had had a similar episode 10 years before, but this had cleared up and she had had no recurrence until recently. At this time, an examination was performed and a malignancy was found at the upper extreme of proctosigmoidoscopic limits. She was admitted to the hospital on Oct. 1, 1950, and left the hospital on Oct. 18, 1950. After preliminary cecostomy, a biopsy of the malignancy showed it to be an adenocarcinoma, grade II. She had a side to end anastomosis after resection and exploration of the abdomen. Her highest temperature was 100.6 F.

Summary

We have presented 3 of our 5 cases of side to end anastomosis for carcinoma of the sigmoid rectum and stated the results.

Miles' operation is the procedure of choice when the patient understands his condition and is of the right mental caliber to live with the end results.

We also feel that this is the procedure of choice in cases in which a frank palliative resection is to be carried out because of obstruction and wide dissemination of the malignancy. We also feel that this method is justified in secondary malignant changes in stalk polypi where the stalk shows no abnormal microscopic structure.

Conclusions

Five cases of carcinoma of the sigmoid rectum were subjected to a side to end anastomosis after resection. At least 1½ inches of rectum must remain to make the operation technically possible. On repeated examinations there has been no local recurrence. The patients are all alive and continent. They are happy and content.

6168 Washington Circle.

REFERENCES

1. Bacon, H. E., and Sauer, I.: Selection of surgical procedure in treatment of cancer of the rectum, J. Internat. Coll. Surgeons 13:24–29 (Jan.) 1950.
2. Baker, J. W.: Controversial trends in cancer of lower sigmoid and rectum, Bull. Mason Clin. 1: 83–92 (Sept.) 1947.

(Continued on next page)

Fig. 3—X-ray barium enema study after resection of carcinoma showing the side to end anastomosis.

3. Baker, J. W.: Surgery of the pelvic colon and rectum, Surg., Gynec. & Obst. 79:92–102 (July) 1944.
4. Baker, J. W.: Low end to side rectosigmoidal anastomosis; description of technic, Arch. Surg. 61: 143–157 (July) 1950.
5. Cattell, R. B.: Carcinoma of the colon and rectum, Surgery 14:378–386 (Sept.) 1943.
6. Coller, F. A., Kay, E. B., and MacIntyre, R. S.: Regional lymphatic metastasis of carcinoma of rectum, Surgery 8:294–311 (Aug.) 1940.
7. Gilchrist, R. K.: Indications regarding operations for cancer of the distal colon and rectum, Surgery 27:787–789 (May) 1950.
8. Gilchrist, R. K., and David, V. C.: Prognosis in carcinoma of bowel, Surg., Gynec. & Obst. 86: 359–371 (March) 1948.
9. Gilchrist, R. K.: A consideration of pathological factors influencing five year survival in radical resection of the large bowel and rectum for carcinoma, Ann. Surg. 126:421–438 (Oct.) 1947.
10. Halligan, E. J., Perkel, L. L., and Catlaw, J. K.: Surgical treatment of carcinoma of the colon and rectum, Am. J. Proct. 1:171–182 (Dec.) 1950.
11. Wangensteen, O. H.: Primary resection (closed anastomosis) of colon and rectosigmoid, including description of abdomino-anal methods for restoration of continuity accompanying excision of carcinoma of rectal ampulla, Surgery 14:403–432 (Sept.) 1943.
12. Whipple, A. O.: Radical surgery in cancer, Ann. Surg. 131:812–823 (June) 1950.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 35 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWG	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WHLA	West Salem	Saturday	10:30 a.m.

Further Experiences with Vein Stripping for Varicose Veins

By JAMES M. SULLIVAN, M. D.*
Milwaukee

THE almost universal switch to vein stripping as the treatment of choice for varicose veins in the past few years attests to its value and has placed it on a firm foundation.[1-6] Even in our original paper, published in 1951 after three years of experience with this technic, we were enthusiastic about the results.[4] In this first paper we compared cases of vein stripping against those of multiple ligation on the surgical service at the Veterans Hospital, Wood. In the present paper we shall evaluate cases encountered in private practice, since they give a better cross-section of the general population and are easier to evaluate because only one observer is involved.

Since March 1950, 152 cases of varicose veins of the extremities—61 per cent of which were bilateral and 39 per cent unilateral—have been treated by stripping and high ligation. This makes a total of 245 extremities which we have treated by this method. Since the material in our previous report was from a veterans hospital, a great majority of the patients were male. In this series, females predominated in a percentage ratio of 76 per cent, not, we think, because varicose veins are more common in women but because women will seek correction of pathologic lesions in the extremities sooner than men because of their mode of dress.

TABLE 1

Total Cases	152	
Total Extremities	245	
Pregnant	30	(19.7%)
Varicose Ulcers	33	(21.7%)
Previous Thrombophlebitis	19	(12.5%)
Previous Ligations	37	(24.3%)
Bilateral	93	(61.2%)
Unilateral	59	(38.8%)
Lesser Saphenous—{17 bilateral, 12 unilateral}	29	(11.8%)
Months Since Surgery ... Average	12.9	
Postoperative Injections ... Average	0.97	

Etiology

The etiologic factors responsible for varicose veins are still shrouded in mystery. Even after a close check on our patients, the hereditary factor was the only one that came up with any degree of consistency. The patients were from all walks of life, every age and economic stratum, and there did not seem to be any common denominator other than a high incidence of varicose veins in their family histories. Almost 20 per cent of these patients were pregnant, and many of the other female patients dated the onset of their varicose veins from their pregnancies. It is our feeling, however, that the pregnancies served merely to aggravate the underlying weakness of the veins, just as the long marches in the military services aggravated the condition of the patients in our group from the Veterans Hospital. It is true, however, that after an attack of thrombophlebitis varicose veins developed in a few patients who had never before had them. These cases seemed to be of the compensatory type and were more apt to be unilateral. We have previously discussed this point.[3]

Diagnosis

Since we have adopted vein stripping as a routine treatment for all major varicosities, the Trendelenburg test[8] and the multiple tourniquet test of Ochsner and Mahorner[7] do not have the same significance they previously had. Nevertheless, we still do them for a more complete evaluation of our patients. When we were doing multiple ligations, the Ochsner–Mahorner multiple tourniquet test was an immense help in picking out the various perforating branches and had to be done very accurately if we were to have any success in picking up these branches. With routine stripping, on the other hand, we tear loose the perforating branches in every case and are bound to get the incompetent ones. We still feel that the Perthes' test[7] is important even though it is seldom positive except in the presence of an acute deep thrombophlebitis. Even in such cases, if the acute thrombophlebitis is given two or three

* From the Department of Surgery, Marquette University.

months to quiet down and the veins to recanalize, the Perthes' test will be found to be negative in every instance. We hesitate to strip veins in patients who have a recent history of acute deep thrombophlebitis, but if they have had no acute symptoms within six months to a year, we feel there is no danger. One diagnostic point that we think is frequently neglected is testing the competency of the lesser saphenous. Twenty-nine of our patients had stripping of the lesser as well as the greater saphenous vein. This percentage seems to have risen in the last year or so.

Technic

The technic has not varied much from our original description.[4] At present we make a vertical incision just lateral to the internal malleolus to pick up the saphenous vein. We have found that a vertical incision will heal better than a transverse one. The stripper is inserted into the vein at this area and passed up to the sapheno-femoral junction if possible. We still use the Crystal stripper and continue to find it satisfactory. When the stripper appears at the sapheno-femoral junction, which we have exposed by an incision, we continue to do a routine high ligation and then substitute a button for the acorn tip and tie the vein to the stripper as close to the button as possible. This seems to prevent invagination. In most cases we prefer to strip downward, because there seems to be less chance that the vein will slip off the stripper. At the completion of the operation, if the skin of the entire leg is in good condition and free from eczema, we place layers of Kurlex from the sapheno-femoral junction to the ankle over the course of the vein which has been removed and then wrap the entire leg in elastoplast. If there is eczema of the lower leg, we substitute an Ace or Tensor bandage for the elastoplast in this area. We see no reason for making extra incisions along the leg as suggested by de Takats[1] and others[6] to tie branches separately because these are torn lose by removing the main branch of the greater saphenous vein. Postoperatively, our patients are given injections where necessary. These average less than one per patient.

Varicose Veins with Varicose Ulcers

Thirty-three of our patients, or 21.7 per cent, had varicose ulcers associated with their varicose veins. It has been our practice to heal these ulcers before active treatment is begun on the veins, but in 3 patients the veins were treated before the ulcers were completely healed. In 1 patient we stripped the vein to within about four inches of the ulcer and then continued to apply supportive dressings. The ulcer healed without any difficulty and no further surgery was required. In 2 other patients it was difficult to get the ulcers completely healed. In these we stripped the veins directly under the ulcer up to the sapheno-femoral junction after cleaning the ulcers with hot boric packs as much as possible and covering the patient with antibiotics before surgery was done. There was no infection in either of these patients but we prefer to avoid operating under these circumstances because of the risks involved and because it violates many surgical principles. For the direct treatment of ulcers we rely on the prepared Unna paste boots to a great extent, as these are easy to apply and do not give the patient much discomfort. In the patients that do not respond either to this or to rubber sponge dressings, we insist that they go to bed and apply boric or Burrow's solution compresses until the ulcer is brought under control. We then continue with prepared Unna paste boots. We use no ointment other than plain Vaseline or boric ointment because the patients usually have previously been sensitized to the innumerable ointments available.

The post-thrombophlebitic ulcer is treated exactly as above. Ligations of the deep veins —vena cava, common femoral, superficial femoral, and popliteal—have all been abandoned as worthless procedures.

Varicose Veins in Pregnancy

Of the 152 patients who had vein strippings, 30, or just under 20 per cent, were pregnant. These received excellent results from their strippings and no complications developed. We do not hesitate to take care of these patients' veins at any stage of pregnancy and, except for slight technical difficulty at the high ligation during the last trimester of pregnancy, we see no reason for prefering one trimester to another. Several recent papers on the active treatment of varicose veins during pregnancy[2] and our own results,[3] reported in 1950, completely convinced us that pregnancy *per se* does not contraindicate active treatment of varicose veins. We are continuing to treat them in this manner.

Thrombophlebitis

A history of previous thrombophlebitis was found in 12.5 per cent of our cases. At first sight we would be inclined to think that these represented the cases of compensatory varicose veins forming after a thrombophlebitis. In over half of these, however, the varicose veins had developed in *both* legs even though the thrombophlebitis had affected only one leg. This leads us to the opinion that even in this low percentage the possibility of varicose veins was present before the thrombophlebitis made its appearance. In another study[9] of patients with thrombophlebitis, we found that over half had varicose veins before their thrombophlebitis developed. It is difficult, therefore, to decide which disease predisposed the other. We believe that there is less chance of thrombophlebitis if varicose veins are eradicated before any other surgery is contemplated or before the child-bearing period begins.

Results

Over 90 per cent of the results given in table 2 were either excellent or good. The 10 fair results were in patients on whom we reoperated. In these second operations a good deal of improvement was made, but the patients did not feel they could estimate it above fair. At any rate, they were content with the improvement obtained. In each of 2 patients whose eventual results were good, an old, deep thrombophlebitis was discovered which took about three months to quiet down.

TABLE 2

Total Cases	152	
Total Extremities	245	
Results		
Excellent	82	(53.2%)
Good	60	(39.5%)
Fair	10	(7.3%)
Poor	0	(0.0%)
TOTAL	152	(100.0%)

After this the legs improved considerably. Since this experience, we hesitate to operate on patients with a history of thrombophlebitis unless at least six months or more have passed without recurrence. Thirty-seven of our patients had had previous ligations that were unsatisfactory because they were incomplete. These were all successfully stripped.

Conclusions

(1) Varicose veins handled by vein stripping and ligation can be treated in well over 90 per cent of cases with permanent good results.

(2) Pregnancy is not a contraindication for active treatment of varicose veins.

(3) Varicose ulcers will remain healed after satisfactory treatment of the veins.

(4) It is unwise to strip veins in patients who give a history of thrombophlebitis until six months or more have elapsed.

161 West Wisconsin Avenue.

REFERENCES

1. de Takats, G., and Fowler, E. F.: The management of varicose veins of the lower extremities, S. Clin. North America, 31:1463–1480 (Oct.) 1951.
2. Quattelbaum, F. W., and Hodgson, J. E.: The surgical treatment of varicose veins in pregnancy, Surg., Gynec. & Obst. 95:336–340 (Sept.) 1952.
3. Sullivan, J. M.: Varicose veins in pregnancy, Wisconsin M. J. 49:291–296 (April) 1950.
4. Sullivan, J. M., and Merdinger, W. F.: Vein stripping versus multiple ligations, Wisconsin M. J. 50:357–360 (April) 1951.
5. Swinton, N. W., and Graham, F. B.: The treatment of varicose veins of the lower extremities, S. Clin. North America, 32:961–970 (June) 1952.
6. Vaughn, A. M., Annan, C. M., and Caserta, J. A.: Modern trends in the treatment of varicose veins, S. Clin. North America, 32:287–297 (Feb.) 1952.
7. Mahorner, H. R., and Ochsner, A.: A new test for evaluating circulation in the venous system of the lower extremity affected by varicosities, Arch. Surg. 33:479–492 (Sept.) 1936.
8. Trendelenburg, F.: Ueber die Unterbindung der Vena saphena magna bei Unterschenkelvaricen, Beitr. z. klin. Chir., Tübing 7:195–210, 1890–1891.
9. Sullivan, J. M., and Walske, B. R.: Thrombophlebitis; an evaluation of various methods of treatment, Am. J. Surg. 79:355–360 (March) 1950.

MARK THESE DATES ON YOUR CALENDAR!

The 1953 Annual Meeting of the State Medical Society will be held on Tuesday, October 6, through Thursday, October 8, at Milwaukee. *If you are a delegate:* Note that the first meeting of the House of Delegates is tentatively set at 10:00 a.m., Monday, October 5. *If you are a golfer:* The golf tournament will be held at North Hills Country Club, Milwaukee, Monday, October 5, during the afternoon. Dinner and awards that evening.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

REPORT OF A CASE*

History. This 46 year old white male was last admitted to Wisconsin General Hospital with the chief complaint of ecchymotic areas on his hands, abdomen, and thighs. The ecchymoses were first noted 14 days before admission; but on closer questioning, it was discovered that there had been petechiae intermittently on the chest for two to three months. However, a dental extraction a month before had resulted in no significant bleeding. Sore throat, laryngitis, cough, fever, and hemoptysis had developed ten days before the onset of ecchymoses. A diagnosis of possible pneumonia was made, and the patient was treated daily with penicillin and Aureomycin for five days preceding admission. For two days after the onset of the respiratory infection, the urine was dark brown to black. No oliguria was noted. The patient had a long history of headache, gastrointestinal symptoms, and "nervousness" that first developed while studying for the priesthood. Symptoms consisted of food intolerance, constricting band-like pain in the head, and a "nervous breakdown" in 1926. These symptoms recurred in 1928 after he left the seminary, and he was admitted to this hospital with marked weight loss and anorexia. In 1928, shortly after his marriage, he was readmitted because of the same symptoms. He was hospitalized in 1937 for "colitis" and again in February to July 1952 for a second "nervous breakdown." During the latter period he received 10 electric shock treatments. Drug ingestion and possible exposure to toxic substances were as follows: Butisol and phenobarbital, three times a day, in ¼ grain doses each for the past five months; occasional ASA for headache; and exposure to pyrethrum, a fly spray, for several months. This insecticide was circulated through the heating system. Both the patient and his wife stated that the petechiae antedated this. The family history was negative for hemorrhagic tendencies.

Physical Examination. Pertinent physical findings were those of slight obesity, pallor, apprehension, tension, subsiding purpuric areas on abdomen and extremities with larger fresh areas over sites of recent penicillin injections, numerous petechiae on legs and thighs, fresh petechial lesions in the mucous membrane of the mouth, and fresh retinal hemorrhage on the left. Cardiac size was normal and pulse rate was 96 per minute with frequent premature contractions. Blood pressure was 178/84 mg. of mercury. The spleen was not palpable.

Laboratory Examination. Initial blood: hemoglobin 8.8; red blood cell count 2,800,000; hematocrit level 24 per cent, total white blood cell count 8,100. Differential: neutrophils 16; lymphocytes 48.4; mononuclears 1; unclassified 5.0; large cells 23.4 (toxic; nuclei in many almost filled the cell); others 1.6. Indices: mean corpuscular volume 85.8, mean corpuscular hemoglobin 31.5, and mean corpuscular hemoglobin concentration 36.6 per cent. Bleeding time: fibrin at 3 minutes and clot at side 5 minutes with seeping through to 15 minutes. Clot retraction: fair at 4 hours; 60 to 65 per cent of normal in 24 hours; clot soft and friable. Tourniquet test showed a few definite petechiae in 5 minutes. Prothrombin time 52 per cent. Platelets were greatly reduced in number—44,000. Red blood cell count: mild anisocytosis and poikilocytosis and a few polychromophilic cells; erythrocyte sedimentation rate was 10. Blood culture was repeatedly negative. Stool: 4 plus guaiac. Urine: specific gravity 1.019; acid; albumin 1.02 per cent; microscopic uncentrifuged white blood cells 4.6 per cent, many red blood cells, and benzidine positive. Urine urobilinogen was negative. Chest x-ray: lung fields negative for significant pulmonary disease. Sternal marrow, neutrophils 2.6; metamyelocytes 3.9; neutromyelocytes 55; eosinophilic myelocytes 0.2; promyelocytes 2.1; unclassified 1.5; lymphocytes 6.0; plasma cells 0.1; blasts 5.0; pathologic cells 4.8; megakaryocytes 0.1; normoblasts 14.3; pronormoblasts 2.2; erythroblasts 0.6. Reticulocytes 3.9 per cent. Platelets scanty. Final blood studies: hemoglobin 6.9; white blood cell count 1,850;

* From the University Hospitals and University of Wisconsin Medical School.

neutrophils 15; lymphocytes 38; mononuclears 14.4; myelocytes 1; blasts 1; unclassified 5; undifferentiated 26. Platelets markedly reduced.

Course. The patient showed no improvement. Bleeding continued with extension of the ecchymoses and petechiae. From the second hospital day the urine was grossly bloody and the stool gave a 4 plus guaiac. The temperature range was between 99 F. and 102 F. Therapy consisted of vitamin B_{12} and repeated transfusions, the latter given daily for the first few days without any increase in hemoglobin values. On the twelfth hospital day he showed a sudden change—drowsiness, confusion, incontinence of bloody urine, and coffee ground vomiting. The pulse was rapid, 120 per minute, temperature 102 F., and blood pressure 160/50. Vomiting persisted, and he raised small clots of blood by coughing. About four hours later Cheyne–Stokes respiration, cyanosis, upward rotation of the right pupil, and pinpoint left pupil with lateral deviation developed. No unilateral muscle weakness or pathologic reflexes were noted. The patient died early the following morning.

Clinical Discussion

Dr. D. R. Korst: This 46 year old white male was last admitted to this hospital with ecchymotic areas on the hands, abdomen, and thighs. These ecchymoses were first noted 14 days before admission, which suggests a hemorrhagic disease of at least this duration. It is possible that the disease began two or three months earlier. Arguing against this conclusion is a dental extraction a month earlier which was not associated with bleeding. Sore throat, laryngitis, cough, fever, and hemoptysis developed 10 days before the appearance of the ecchymoses. A diagnosis of possible pneumonia was made, and the patient was treated with penicillin and Aureomycin. This raises the possibility of agranulocytosis associated with purpura. However, the drugs were used after the acute onset. We do not know the response to the antibiotics. Mention is made of a dark colored urine. No jaundice was mentioned in the protocol, so we can assume this to be a gross hematuria.

There is a history of headaches, gastrointestinal symptoms, and nervousness for 25 years. The past history is interesting and suggests a long-standing mental illness. Shock therapy was used in the spring of 1952, suggesting a severe psychiatric disorder. However, it seems doubtful that this past medical history contributes to the illness under consideration.

Drug ingestion must be considered because several drugs are mentioned. Butisol and phenobarbital were used over a five month period. There are rare reports of agranulocytosis attributed to the barbiturates. The validity of these seems doubtful considering the widespread use of barbiturates. I doubt whether this had any relation to the present illness, but if amidopyrine had been mentioned that, of course, would be a different matter. Pyrethrum, an extract of chrysanthemum flowers, was used as a spray. It is a commercial house spray ordinarily used as an aerosol insecticide. Some experimental work with pyrethrum has been done on rats by the Mellon industrial research group in Pittsburgh. They were unable to produce any toxic effect with pyrethrum in concentrations far above that which would be used in households or commercially. No evidence was found of the toxic effect of pyrethrum on man. Mention is made of resinous impurities in crude pyrethrum that could possibly be a toxic factor. The specific pharmacologic action of pyrethrum is as a stimulant, a sialogogue, an irritant, and a rubefacient.

Mention was made of physical examination of widespread new and old purpuric areas. Mucosal petechiae were noted, but there was no mention of throat lesions. In agranulocytosis one might expect ulcerations of the mucosa. Retinal hemorrhage was mentioned, and this is significant because it occurs in about 70 to 90 per cent of cases with acute leukemia and in about 75 per cent of cases of aplastic anemia. The spleen was not felt. It is palpable in about two thirds of the cases with acute leukemia. There was no mention of the lymph nodes or of sternal tenderness.

The initial blood count indicated a normocytic normochromic anemia, and there was a leukopenia. The picture of changing blood count and the progressive pancytopenia certainly suggest failure of the bone marrow. The clotting and bleeding times suggest a platelet defect which is supported by the low platelet count of 44,000 and also by the few platelets in the marrow. The tourniquet test was incompletely described, but I will assume that it was abnormal. The prothrombin time of 52 per cent is low. We do not know whether this was due to liver impairment or

lack of vitamin K. Stool and urine reports indicate hematuria and melena as would be expected with this degree of thrombopenia. In addition to the chest x-ray report, I would like to know whether there was any hilar adenopathy or thymus enlargement. No mention is made of reticulocytes in the peripheral blood, but we are told that there was 3 or 4 per cent in the marrow.

From the changes reported in the bone marrow, one would not be willing to make an unequivocal diagnosis of leukemia, as this marrow picture probably represents a refractory anemia or aplasia of the bone marrow with arrest at the myelocyte stage. Of more value here than the actual differential count, I think, would be the gross appearance of the bone marrow or its appearance under the low power of the microscope. A more cellular marrow might be more suggestive of leukemia. An acellular marrow would favor an aplastic anemia. In an acute refractory anemia, however, the bone marrow, if it is not maturing, may still be hyperplastic.

In the hospital the patient showed little improvement. The time from the onset of ecchymoses until death was only 26 days. There was evidently little response to therapy. The terminal episode in this case suggests a gross gastrointestinal hemorrhage and finally a subarachnoid hemorrhage or cerebrovascular accident. I am sure that the gross hemorrhage and the cerebrovascular accident were the immediate cause of death. It is obvious that my differential diagnosis lies between acute leukemia and an aplastic anemia. Both conditions could cause this short fulminating course. Both might give the same physical findings and, of course, the failure of response to therapy. This leaves only the laboratory data to help us in our decision. Looking again at the differential counts of the marrow and the peripheral blood, both suggest a progressive pancytopenia without many abnormal or immature cells. The drop in white cells from 8,000 to 1,800, the progressive anemia and fall in hemoglobin in spite of transfusions, and the report of scanty platelets suggest that all elements of the bone marrow are depressed or that there is a failure of maturation. In leukemia I think that we would see more immature forms, particularly in the marrow. The 24 per cent undifferentiated cells mentioned in the final blood count may have been immature forms.

It is possible that the one bone marrow aspiration was taken from a spot which was not truly representative. This seems doubtful, however, since in acute leukemia in this stage the marrow is very cellular. With the evidence at hand, I favor an acute aplastic anemia and, as a close second, acute leukemia.

Dr. D. M. Angevine: Was a biopsy of the bone marrow done?

Dr. R. F. Schilling: No.

Doctor Angevine: There is one other question that I would like to raise in relation to the history. There is a history of taking phenobarbital and Butisol for five months, but his history of repeated nervous breakdowns since 1926 suggests to me that he might have had more sedatives in the past than indicated in the protocol.

Necropsy Findings

(W.G.H. 52:255)

Dr. H. J. van Baaren: Interpretation of the postmortem findings in this case was more complex and difficult than the clinical picture indicated.

The cause of death was subarachnoid hemorrhage with a cerebral hemorrhage which had penetrated into the third ventricle. Microscopy shows that the subarachnoid hemorrhage was a recent one. There was no evidence of older hemorrhages. The cerebral hemorrhage was also recent, and no pigmented macrophages were seen.

The cerebral hemorrhage was part of a generalized hemorrhagic diathesis. The pericardium, as well as the mucosa of the trachea and many other organs, showed many petechial hemorrhages. The kidneys showed hemorrhage within the capsules of the glomeruli as well as hemorrhage into the ureters.

The cause of the hemorrhagic diathesis is clear from the clinical history, which showed a pancytopenia in which thrombocytopenia was an important part, explaining the hemorrhagic diathesis by a lack of platelets.

Here the difficulty arises, the explanation of the thrombocytopenia. The bone marrow was hyperplastic, but while granulopoietic and erythropoietic elements were present in large quantities, megakaryocytes were practically absent. Normally every high dry field should show about one megakaryocyte. These findings were observed in different areas of the bone marrow, vertebral as well as sternal. The smears showed also a near absence of megakaryocytes.

This type of bone marrow picture is difficult to explain. A hyperplastic marrow with abundance in all cell series combined with a peripheral pancytopenia fits into the picture of hypersplenism, but hyperplastic marrow with an isolated absence of megakaryocytes and a peripheral pancytopenia cannot be explained by this assumption. No increase in myeloblasts was seen in the marrow, nor did any of the organs show leukemic infiltration, ruling out a leukemia. The only extramedullary finding in the hematopoietic system was a slight hematopoiesis in spleen and liver, but again megakaryocytes were extremely scarce.

The combination of this very limited extramedullary hematopoiesis with hyperplastic marrow also rules out the possibility of an agnogenic myeloid metaplasia.

I would like to mention an additional finding in the bone marrow found in the smears. Myelocytic elements show rod-like inclusions similar to those observed by Austen in marrow in bacterial endocarditis. We may use them as a possible indication that the bone marrow was influenced by a toxic process.

References to hyperplastic marrow with an absence of megakaryocytes are present in the literature and implicate certain drugs for their causation. While amidopyrine leads to a selective disappearance of granulocytes, some barbiturates and Sedormid have led to a disappearance of megakaryocytes with thrombocytopenia and hemorrhagic diathesis. The history of this patient shows the use of a large number of sedatives in many stages of his life. In addition, he had been exposed to the effects of an insecticide.

It is our opinion that the autopsy findings rule out hypersplenic conditions, leukemias, and agnogenic myeloid metaplasia, and we believe that in this case we might be dealing with a selective destruction of the megakaryocytic system by drugs.

Dr. E. C. Albright: I have a clinical question. Was ACTH used?

Doctor Schilling: No—but not because we expected that it would not help. In answer to Doctor Korst's question about the prothrombin time, which was 52 per cent, we raised it after a few days on vitamin K to 80 per cent, but the clinical manifestations of hemorrhage were unabated, and the patient was passing gross blood in the urine for at least 48 hours before death and had very obvious bleeding from the bowel. The usual finding in the bone marrow in patients who have some form of drug toxicity is quite different from this. While I agree that the findings in the organs are not what one would anticipate in the usual case of acute leukemia, I feel that the offering of drug toxicity or idiosyncrasy is reasonable, but so is the offering of acute leukemia. Obviously we cannot prove that this is drug toxicity, because the patient expired before tests could be performed. By the same token we do not have positive proof of the diagnosis of acute leukemia. The usual bone marrow picture in cases of drug idiosyncrasy would be a marked decrease in the cellularity of the bone marrow. The thing that struck me most about the picture as exhibited by Doctor van Baaren was the uniformity and hypercellularity under low power. The other thing is that extramedullary hematopoiesis is a feature common to leukemia but is not, of course, diagnostic. Another point that I would consider is that these rod-like structures might be an unusual abundance of Auer bodies, which are most commonly seen in certain cases of acute leukemia. Sometimes Auer bodies are found in the cytoplasm of leukemic cells in as high a proportion as 25 per cent. I think that the possibility of an unusual manifestation of acute leukemia is as reasonable as is the suggestion of toxicity. I suppose that it is ridiculous to talk about it because neither of us can offer proof. I would like to ask the pathologists how they feel about leukemic infiltration of the organs. I gathered that a lack of it would rule out leukemia to the pathologist.

Dr. van Baaren. There was no infiltration in any of the organs. The bone marrow picture was an increase in immature white cells in the myelocytic stage. In addition, there was an increase of the erythropoietic elements, so that our impression was not that of a leukemic bone marrow but rather a hyperplastic or regenerating marrow.

Doctor Angevine: One question to be answered is why there should be hyperplasia of the marrow in a toxic disease. This patient did have a fever, cough, and laryngitis 10 days prior to onset and was treated daily with penicillin. Such an infection might well have produced the hyperplasia. There also had been bleeding for five months. Many patients with thrombocytopenic purpura do have some hyperplasia of the red cell elements, so there are two possible explanations for the bone marrow findings.

Doctor Schilling: On marrow aspirate there were 14 per cent nucleated red cells, well within the normal range, and 55 per cent myelocytes, in which a large number of inclusion bodies were found. I do not mean to intimate that calling them Auer bodies lends any special significance to the diagnosis of leukemia. Auer bodies are red rods in the cytoplasm of cells of leukemic patients. I suppose that similar morphologic structures might occur in chemical intoxications.

Dr. F. L. Kozelka: It is not very likely that barbiturates had anything to do with this condition. There is one point that should be mentioned here. It appears that all of the reports of deaths attributed to DDT or pyrethrum ignore the solvents used as vehicles. When these insecticides are administered *per se* intoxication does not occur, yet all reported cases of thrombocytopenia or aplastic anemia have occurred in connection with the use of sprays or aerosol bombs. It is the aromatic hydrocarbons that produce an aplastic anemia. If this individual was exposed to pyrethrum in an oil spray and was so careless as to put it in the heating system, the family might have been exposed to the aromatic hydrocarbons for some time.

Doctor Angevine: But this patient and his wife both state that the hemorrhages were present before this material was put in the heating system.

Doctor Kozelka: Well, if it antedated this it might indicate that he was careless with the sprays, considering them innocuous. For example, the same applies to gasoline; it is no longer what the old term implies. It contains about 50 per cent of the aromatic hydrocarbons.

Doctor Angevine: I should like to refer again to the article mentioned by Doctor van Baaren. The author says, "Although amidopyrine damages the granulocytic system, barbituric acid derivatives damage the marrow giant cells specifically."

Doctor Kozelka: Doctor van Baaren mentioned, I think, Sedormid.

Doctor Angevine: He included that as well, but he also spoke of barbituric acid.

Doctor Kozelka: But Sedormid is not a barbiturate. It is a carbamine. What about epileptic colonies where the patients have been receiving phenobarbital for years? What is the incidence of aplastic anemia in such hospitals?

Doctor Angevine: Once in a while a person is going to have an idiosyncrasy, but I do not know the incidence in such individuals.

Dr. E. R. Schmidt: I was struck by the absence of infection in such a pancytopenia. Usually if throat lesions are present, they progress.

Doctor van Baaren: I did not believe that the infection was causing the pancytopenia, but that the infection may have provided a stimulus to the granulocytic elements of the marrow, which could explain part of the granulocytic hyperplasia; also the hemorrhage might explain part of the erythropoietic hyperplasia in spite of the pancytopenia.

Doctor Schilling: I do not believe that infection will cause a myeloid hyperplasia if a patient has an agranulocytosis.

Doctor van Baaren: We said that the fact that there was an infection might have led to the usual reaction of the bone marrow, namely hyperplasia of the white elements. We were not thinking in terms of an agranulocytic angina.

Dr. H. A. Waisman: I want to reply to Doctor Schmidt that patients with granulocytopenia have remarkable resistance to infection for reasons that seem to be peculiar to patients with acute leukemia. Even under therapy with folic acid antagonists, where there is marrow suppression and the white count as low as in this patient, there is very little infection to complicate the picture.

Doctor Angevine: But terminal infection brings the majority of them to autopsy.

Doctor Waisman: I want to differ with you also on the incidence of intracranial hemorrhage in leukemia. It is hard to understand why a patient should have only a thrombocytopenia with other cells relatively normal. In other words, a patient with leukemia usually has a thrombocytopenia. This case is different in that there is a dissociation in which the thrombocytes are low and all of the other cells seem to be relatively normal. I wonder why myeloid metaplasia could not explain what you saw in the marrow and the blood loss account for the erythropoiesis. In other words, this was not an overwhelming stem cell replacement of the bone marrow.

Doctor Angevine: It is our opinion that the erythropoiesis was due to the blood loss. We also did not consider the bone marrow to represent leukemia.

The Diagnosis of Illness Due to Excessive Lead Absorption

As It Looks to Your State Board of Health

MANY cases of excessive lead absorption do not originate from occupational exposure. It is entirely possible, for instance, for an individual to absorb a toxic amount of lead by continually drinking water transported from the main in the street to the tap in the house through lead pipes. Lead piping within dwellings is, of course, found only in very old houses. There are a number of lesser sources of lead intake to the body in normal everyday life, as evidenced by the presence of lead in the urine in concentrations ranging from 0.01 to 0.10 mg. of lead per liter of urine. Lead is also a normal constituent of blood, being present in concentrations ranging from 0.01 to 0.05 mg. per 100 Gm. of blood.

Cases apparently involving excessive absorption of lead do not, as a rule, stand out as being definitely related to the patient's occupation, even though his occupational history indicates that he works with lead or some compound of lead. The symptoms reported by the patient may be typical of a number of fairly common conditions. Excessive exposure to lead, a cumulative toxic heavy metal, may produce symptoms ranging from fatigue, anemia, or mild gastrointestinal disturbances as a result of low-level chronic exposure, to colic and encephalitis from acute or massive exposures. In the event that the patient's occupational history reveals that he has a possible exposure to lead, it becomes very important to determine whether the principal source of his lead intake is occupational or otherwise.

Diagnosis of cases of excessive lead absorption or of lead poisoning resulting from occupational exposure is important from at least three standpoints. (1) The occupational exposure must be brought to a safe level before the patient returns to his job. (2) Other persons, fellow workers or the patient's replacement, are also possibly being exposed to excessive lead concentrations in their work. (3) In all probability the patient's case will become a compensation case heard before the Industrial Commission, unless the case is so well defined that it will not be contested.

Briefly, it may be said that a sound diagnosis is based upon three essentials: (1) a characteristic clinical picture; (2) evidence of significant exposure; and (3) laboratory data: quantitative data on the lead content of the urine or blood and the hematologic picture. These three basic types of information must be interpreted together.

"Evidence of significant exposure" requires accurate figures on dosage. Dosage in industry is as important as in a prescription. Information on this point quite often may be obtained only by a technical evaluation of the employee's working environment. A study of this nature involves the determination of the average lead concentration in the air at the worker's breathing zone as well as in the general atmosphere immediately adjacent to his area of employment. The findings of an evaluation study may then be compared with accepted standards, published as Order No. 2002 in the Industrial Commission Code entitled *Dust, Fumes, Vapors and Gases*. The practicing physician is obviously not expected to make such a study, but in Wisconsin he may call upon the Division of Industrial Hygiene of the State Board of Health to render this service.

"Laboratory data" should present quantitative data on the concentration of lead in the patient's urine or blood. Quantitative hematologic data on the hemoglobin content and the stippled cell count should also be determined in the laboratory.

Since the accurate chemical determination of the lead content of urine or blood specimens is an intricate procedure requiring highly purified reagents and specially trained laboratory personnel, there are very few laboratories in Wisconsin which perform this type of chemical analysis. Lack of laboratory facilities need not deter the physician from including this important determination in his diagnosis, however, since the State Laboratory of Hygiene will, upon written request,

(Continued on page 290)

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Questions and Answers Suggested by Recent Investigations in Drug Therapy

Under what circumstances may thiocyanate psychosis be expected to occur most frequently? The occurrence of thiocyanate psychosis is much less frequent in carefully studied series of cases than when the drug is used in sporadic and uncontrolled fashion. In reporting 8 such psychoses, Barnett[1] pointed out that several difficulties hinder prompt recognition of thiocyanate psychosis. The delirium varies from mildly stuporous, confusional states to delusional, hallucinatory, or maniacal outbursts. The psychosis resembles and indeed may coexist with bromide psychosis. After the onset of mild confusion the patient may unwittingly further overdose himself. Increase in the severity of the psychosis when the drug has been discontinued does not invalidate diagnosis, as demonstrated in 2 of these 8 cases. Nor should focal neurologic signs allow the diagnosis to be missed. Half of these patients were considered by the physicians to be the victims of cerebral vascular disorders. The serum should be analyzed for thiocyanate content in any patient with delirium of obscure origin, particularly if hypertensive.

Why has benemid been alleged to be useful in the treatment of tuberculosis? A mean increase in plasma concentrations of PAS as the result of the concomitant employment of benemid has been reported by Israel.[2] The chief advantage of the combination appeared to be in increasing plasma PAS concentration in patients who could tolerate only small doses of PAS rather than in improving the results achievable with high PAS dosage.

Why is it that Banthine often is not completely successful in relieving the pain in peptic ulcer? The logical conclusion as to the mechanism of pain relief by Banthine, to be drawn from the work of Legerton,[3] and others, is that it decreases gastrointestinal motility by blocking the parasympathetic motor innervation of the stomach and duodenum. The important point, however, is that it does not seem to inhibit the sigmoid hypermotility of stress and emotional conflict.

By inference from animal experimentation, what combination of antibiotics should not be used in pneumococcic infections? In the experimental pneumococcal infection in mice in which chloramphenicol (Chloromycetin) is peculiarly ineffective, the addition of this drug to penicillin abolishes the very considerable therapeutic activity of the latter drug. Mice treated with this combination of drugs actually die almost as quickly as untreated controls.—HARRY BECKMAN, M. D.

REFERENCES

1. Barnett, H. J. M., Jackson, M. V., and Spaulding, W. B.: Thiocyanate psychosis, J.A.M.A. 147:1554–1558 (Dec. 15) 1951.
2. Israel, H. L., Mick, F., and Boger, W. P.: Effect of prolonged administration of p-(di-n-propylsulfamyl)-benzoic acid (benemid) on plasma concentrations of para-aminosalicylic acid, Am. Rev. Tuberc. 64:454–460 (Oct.) 1951.
3. Legerton, C. W., Jr., Texter, E. C., and Ruffin, J. M.: The mechanism of relief of pain in peptic ulcer by Banthine, South. M. J. 45:310–317 (April) 1952.

EXCESSIVE LEAD ABSORPTION

(Continued from preceding page)

make quantitative determinations of lead in either urine or blood specimens.

Since the amount of lead which is significant in either blood or urine is very small, special precautions must also be observed in collecting and shipping specimens for analysis. These special directions, covering the type of containers, syringe, and needle to be used, will be furnished by the State Laboratory of Hygiene on request.—WILLIAM L. LEA, PH.D., *Director, Industrial Hygiene Division, State Board of Health.*

THE MEDICAL FORUM

COMMISSION ON STATE DEPARTMENTS MEETS IN MADISON

Neupert Is Delegate to Meeting of World Health Organization

Madison, May 2.—Dr. Carl N. Neupert, state health officer, left today to fly to Geneva, Switzerland to attend the Sixth World Health Assembly as a member of the U. S. delegation.

Dr. Neupert was appointed to this delegation by Mrs. Oveta Culp Hobby, Secretary of the new Department of Health, Education and Welfare.

Dr. Neupert is serving on the delegation program committee and is advising on technical discussions on the control of tuberculosis, venereal diseases and the typhoid group of fevers. He is taking an active role in the discussions of the WHO's programs in the control of communicable diseases. According to Mrs. Hobby, several items were to be assigned to him during the meeting which he is to discuss in behalf of the United States government.

Well known throughout Wisconsin for his weekly health articles,

DR. C. N. NEUPERT

Dr. Neupert is one of the outstanding health officers of the nation. He is currently president of the Association of State and Territorial Health Officers. He is a former chairman of the committee on health of the National Congress of Parents and Teachers.

The World Health Organization is an agency of the United Nations which directs and coordinates health work on an international scale.

SOUTHWORTH COMPLETES MANUAL FOR MEDICAL TEAMS OF CIVIL DEFENSE

Madison, April 20.—A new manual for the personnel of mobile medical teams has been prepared and edited for the Office of Civil Defense by Dr. Warren H. Southworth, professor of health education at the University of Wisconsin.

The manual contains the cold facts about the atomic bomb. It outlines the state organization for civil defense and the make-up of mobile medical teams. It covers the emergency treatment of disaster casualties and the way to set up and keep records on these casualties. It explains the necessary control of radiological hazards and suggests defenses against biological and chemical warfare. It also supplies suggestions for medical team instruction.

The appendix carries a bibliography of helpful publications for medical team instruction, and lists films and filmstrips for the same purpose. It also suggests forms which can be used by medical team business managers.

The manual begins with a letter from Governor Walter Kohler.

It also carries introductions by Major General Ralph J. Olson, civil defense director, and Dr. Carl N. Neupert, state health officer, who is co-director.

Dr. Marc J. Musser, chairman of the State Medical Society's committee on civil defense, outlines the physician's responsibility in civil defense matters.

Appoints Several New Members; Problems of Departments Outlined

Madison, April 8.—Several new members were appointed to the various divisions and subcommittees of the State Medical Society's Commission on State Departments at the commission's meeting in Madison.

Dr. A. A. Lorenz, Eau Claire, was selected to serve as a member of the Division on Mental and Nervous Diseases, and also of a subcommittee studying the emotional problems of the disturbed child. Dr. Robert O'Connor, Madison, was also appointed to this subcommittee.

Another subcommittee was set up to discuss the subject of residencies in psychiatry, with the following as members: Dr. Chester Wade, Milwaukee, chairman; Drs. H. H. Reese, H. K. Tenney, III, William Bleckwenn, Leslie Osborn and William Middleton all of Madison, and Dr. Keith Keane, Sheboygan.

Study Commitment Laws

Drs. Owen Clark, Oconomowoc, and J. F. Klepfer, Waupun, were placed on the subcommittee to study commitment laws. Dr. Keane is chairman of this subcommittee, and other members include Drs. J. T. Petersik, Winnebago; Walter Urben, Madison, and R. A. Jefferson and Michael Kasak, Milwaukee.

Upon a specific request that a pathologist be added to the Division on Maternal and Child Welfare, Dr. E. A. Birge, Milwaukee, was appointed.

It was reported that Dr. John W. Doolittle, Madison, is representing the Division on Hearing and Vision Defects on the advisory committee of the Motor Vehicle department.

The commission heard the preliminary report of the school survey to determine how many schools

(Continued on page 296)

WISCONSIN BLUE CROSS REPORTS RECORD YEAR AT ANNUAL MEETING

Milwaukee, April 27.—The 13th annual report of the Associated Hospital Service, Inc., the non-profit, hospital-operated and sponsored prepayment plan for hospital care, showed new highs in membership, in hospital admissions and in payments to hospitals.

This was reported to members of the corporation at its annual meeting in Milwaukee on April 27. Members of the corporation consist of hospital administrators, physicians, and public representatives, all nominated by hospitals who are participating in the plan.

Leon R. Wheeler, executive secretary, reported total membership in Blue Cross at the end of 1952 was 878,089, a gain of 62,749 for the year. Total membership in the two medical–surgical Blue Shield plans sponsored by the State Medical Society and Milwaukee County Medical Society, and for which Blue Cross is enrolling agent, stood at 645,096. This was a gain of 74,089 members over 1951.

Great National Growth

Nationally, Blue Cross plans had a net growth of over 2,375,000 members, bringing the total Blue Cross membership to approximately 44 million.

Mr. Wheeler attributed the favorable growth of Blue Cross in Wisconsin to a number of factors, such as flexibility of choice by subscribers, continuing extension and broadening of benefits and sound enrollment regulations.

Experience of the past two years proves conclusively, said Mr. Wheeler, that the majority of the subscribing public wants the broadest possible protection for acute hospitalization. Almost 55 per cent of Blue Cross group membership are now covered under the Comprehensive contract of Blue Cross, which is calculated to pay 92 per cent of the average hospital bill.

Total Blue Cross admissions paid for in 1952 was 135,540. One out of every six Blue Cross members used hospital care in 1952.

To pay for this care during 1952, Blue Cross paid out over $10,100,000, an increase of $2,375,000 over the previous year.

Total payments for care rendered to this plan's members from 1940, when the plan got started, through 1952 was over $44,845,000.

Mr. Wheeler pointed out that the larger payments to hospitals were due to three reasons: 1) the steady broadening of subscriber benefits provided by Blue Cross; 2) the continuing increase in admissions per thousand members, and; 3) increased hospital charges due to increased cost of hospital operation. The average charge for a day's hospital care from 1948 through 1952 has risen 72.2%. Average per diem charge by hospitals for care in 1952 was $18.34.

Operating expenses for 1952 amounted to 8.2% of the subscriber's income dollar.

Progress Encouraging

Mr. B. E. Miller, Madison, who is president of the Blue Cross plan, said: "Last year's record of our plan's operation should be encouraging to everyone who has an interest in Blue Cross, and that, I feel, means practically everyone in Wisconsin who is interested in advancing our general health standards. Our hospitals should be pleased with the contribution Blue Cross is making toward stabilizing their financial operations. Our subscribing public should feel a growing sense of security with our efforts to expand the benefit schedules in our contracts. Wisconsin physicians should be encouraged by our efforts to enroll members in their surgical–medical plans."

Court Renders Decision for Board of Pharmacy

Madison, April 1.—A decision of importance to the field of pharmacy was handed down by the Wisconsin Supreme Court in March. It affirmed the validity of using the definition of drugs as contained in the Wisconsin Pharmacy Law, in which articles of the National Formulary and their supplements are held to be drugs.

The case which resulted in the legal contest over the validity of the statute was one in which a La Crosse grocery store operator was found guilty in the County Court of selling aspirin, milk of magnesia and camphorated oil without being a registered pharmacist. Suit was brought by the Wisconsin State Board of Pharmacy.

AAGP Calls Hawley's Statements to Press Disservice to Medicine

St. Louis, April 1.—At its March meeting in St. Louis, the American Academy of General Practice considered a number of resolutions designed to censure Dr. Paul Hawley, director of the American College of Surgeons, for his criticism of the medical profession for performing unnecessary surgery and for splitting fees.

Dr. Hawley's remarks delivered at a Tennesse county medical society meeting in February were widely publicized, first in the daily press and later in an article in the U. S. News and World Report.

Dr. Hawley's accusations were interpreted as being highly derogatory to the field of general practice. He was answered in the public press and later in the U. S. News and World Report by Dr. R. B. Robins, Camden, Ark., retiring president of the Academy of General Practice.

Dr. Robins stated that Dr. Hawley had done medicine a great disservice by attempting to undermine public confidence in the medical profession. He said that "probably 70 per cent of the surgery in this country is done by general practitioner surgeons, and I shudder to think of the increased morta'ity, for example, from acute appendicitis if general practitioners were not permitted to do major surgery."

The academy unanimously adopted a resolution calling on state chapters to transmit reports of the offending remarks to the American Medical Association. Another resolution requested the AMA to consider some means of avoiding repetition of similar damage to medicine's public relations in the future.

Bill Drawn to Extend MD's $100 Special Pay

Washington, April 17.—The Defense Department has drawn up its proposed bill for extending the $100 special pay for military medical men and sent it to the Budget Bureau for approval. Without specific action by Congress, this equalization pay would not be available to men who are called into service after next June 30.

State Chambers Suggest Return to States of Federal Health and Welfare Programs

Chicago, April 10.—The Council of State Chambers of Commerce has gone on record as favoring a return to the states of most of the welfare programs now administered or supervised by the federal government.

According to the *Insurance Economics Surveys*, the council also urged that the government relinquish to the states its claims to such sources of revenue as the estate tax, gift tax and admission and cabaret taxes to furnish funds for state operation of the welfare programs.

According to the council's Washington research staff, employers of eight or more persons are liable to a federal tax of 3 per cent on payrolls, but can be relieved of nine-tenths of this levy by paying unemployment compensation tax to the state.

The remaining one-tenth is collected by the Federal government and doled out to the states for administration of welfare programs. The council contends that revenues thus collected are far in excess of the grants to the states.

"If this tax source were transferred to the states along with responsibility for financing administrative costs of the activities," the council's report held, "practically every state would have more than enough funds to do a better job than is being done under the present grant system."

The council insisted that the transfer could be made "without fear that some states might drastically lower their standards or even give up these services." This would be precluded by the fact that employers would have to pay the full 3 per cent tax to the federal government if the state failed to provide unemployment compensation and public employment services.

The programs the council would like to see transferred to the states are public assistance, including old-age assistance for those not eligible under Social Security; aid to the permanently disabled, aid to the blind, aid to dependent children, the national school lunch program, cooperative vocational education, general health assistance and the Children's Bureau program.

DR. W. B. HILDEBRAND

HILDEBRAND TO HEAD ACADEMY OF GENERAL PRACTICE NEXT YEAR

St. Louis, April 6.—Dr. William B. Hildebrand, Menasha, was chosen president-elect of the American Academy of General Practice at the academy's annual meeting late in March.

He will assume the presidency at the 1954 meeting, when he will succeed Dr. U. R. Bryner of Salt Lake City.

Dr. Hildebrand has just retired as president of the board of directors of the academy. He has been secretary-treasurer of the Wisconsin Academy of General Practice since its inception, and has also been active in the medical society of Winnebago county.

Dr. Hildebrand saw three years of Navy service during World War II. He is a medical graduate of Washington university, St. Louis.

Plasma for Emergency Use Contracted for by Civil Defense Office

Madison, April 10.—Major General Ralph J. Olson, state civil defense director, has announced that his office has contracted with the Junior League Blood Center, Milwaukee, to provide the plasma for the medical teams of the state mobile support program.

More than 1,850 blood sets, including plasma, diluent and recipient sets are expected to be delivered by the end of June. In all, 7,140 sets will be procured for the medical teams, to be used in case of enemy attack.

This number is considered a bare minimum of what the teams will need for their first six hours of operation if a Hiroshima-type atom bomb were to be dropped on Wisconsin. The federal stockpile is expected to be the source of plasma for the teams after the state supply is exhausted.

Dr. Carl N. Neupert, state health officer, who is co-director for health services for the state civil defense organization, has worked with medical advisory groups representing state and county medical societies, to determine the needs of the medical teams. He is working out a plan for rotating the plasma so that the available supply is always less than three years old. Since plasma has a life of five years, a fresh supply will always be assured by rotating the state-procured supply at the end of three years after its receipt.

The state civil defense office is getting the plasma at cost—$14 per unit, which will be paid for by the federal and state governments on a 50–50 basis. A total of 102 medical teams is being organized.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

MODEL SCHOOL VISION SCREENING PLAN OUTLINED, DISTRIBUTED BY SMS GROUP

Madison, April 8.—A model school vision testing program which may be carried out at the local level in various communities has been developed by the Division on Visual and Hearing Defects of the State Medical Society's Commission on State Departments.

Detailed outlines of the projected program have been sent to all school administrators in the state, and county medical societies have also received copies.

Any physician who wishes to receive one of these outlines may write to the State Medical Society in order to secure one. It will be in the June *Journal*.

This testing program suggests that each locality intending to launch a screening project set up a planning committee consisting of a public health nurse, school personnel representatives, members of PTA and health councils or panels, local health officers and other interested persons. An ophthalmologist should also be consulted in an advisory capacity.

It has been suggested that the public health nurse serve as director of the program.

The planning committee should determine what test is to be used and at what school level children are to be tested. The usual procedure is to screen grades 1, 4 and 7 annually.

Tests should be administered by the nurse and a volunteer group of mothers who will receive the necessary instruction from the nurse or a medical committee. The nurse or some specially trained lay person should re-check every child who fails to pass a normal vision test.

Form letters should be worked up to send to parents of children who need to be referred to an eye doctor for further examination, and there should be a follow-up letter or a call by the nurse to such parents as do not follow the recommendation to have their children checked by a physician.

It is further suggested that the planning committee try to interest service clubs and other organizations in offering financial aid to be used for the purchase of testing equipment, the cost of stationery and postage for form letters and the assistance of needy families who require glasses or surgery.

Dr. T. L. Tolan, Milwaukee, is chairman of the division which developed the program. He was assisted by Drs. E. J. Zeiss, Appleton; A. B. Schwartz, Milwaukee and J. W. Doolittle and W. M Nesbit, Madison.

WISCONSIN RECEIVES $40,000 IN GRANTS FOR HEART RESEARCH

New York, April 9.—Grants and fellowships in the field of heart disease research totalling approximately $40,000 have been awarded to Wisconsin hospitals, doctors and students.

The grants have been announced by the Life Insurance Medical Research Fund, an organization of 145 U. S. and Canadian life insurance companies. More than $810,000 has been awarded as grants-in-aid to university hospital and research centers and in scientific fellowships to young men and women.

To the University of Wisconsin Institute for Enzyme Research goes a grant of $17,280 for research by Dr. Henry A. Lardy on fundamental aspects of intermediary metabolism, with particular reference to the heart muscle.

The University of Wisconsin medical school is to receive two grants, one of $10,422 for research by Dr. F. E. Shideman on energy sources for the renal tubular transport of sodium; the other for Dr. William B. Youmans on cardiovascular and renal adjustments to decreases in peripheral resistance.

A postdoctoral research fellowship has been granted to Dr. Donald Lewis Fry of Hudson for work under Dr. Richard V. Ebert at the University of Minnesota medical school, Minneapolis.

A predoctoral fellowship has been granted to Elsworth R. Buskirk, M. A., Beloit.

COMMISSION ON STATE . . .

(Continued from page 291)

are now requiring health examinations of teachers and other school personnel to give evidence of freedom from tuberculosis.

It was further reported that a guide for the development of a local or regional rheumatic fever program which has been prepared by Dr. A. B. Weinstein, Madison, will soon be ready for distribution to medical societies and to groups interested in the development of local rheumatic fever programs. Those interested in securing one of these guides should write to the State Medical Society.

Mr. George Keith of the State Department of Public Assistance addressed the commission, indicating that the hottest issues in regard to this subject are the matter of charges for public welfare patients, and the heavy load of these patients that is carried by certain physicians in specific areas.

Mr. Adrian Towne of the Department of Vocational Rehabilitation stated his desire to learn whether the commission's Division on Rehabilitation is to act as an advisory committee to the Division of Rehabilitation of the Industrial Commission. He pointed out that there are many special problems related to fees which would indicate the advisability of having consultation on these special problems.

Speaking for the State Department of Public Instruction, Mr. George Watson indicated two areas in which he hoped that consideration would be given both by the commission and the Committee on School Health. He stated that there is need to determine policies as to what extent health services should be rendered through the schools or through local health agencies. He also felt that schools, in the role of health educators, sometimes unconsciously get into fields which may well be the responsibility of other groups.

Dr. C. N. Neupert, state health officer, outlined the development of procedures for the distribution of gamma globulin. Dr. Leslie Osborn told of some problems which are of concern to the Division on Mental Hygiene of the Department of Public Welfare. These included TB control in mental institutions, the anticipated development of a central colony of patients at Mendota which will provide teaching material for the University of Wisconsin Medical School, the greater need for facilities at Central State hospital, and alcoholism studies now being carried out.

COUNCIL COMMITTEE MEMBERS NAMED FOR 1953-54

Madison, April 15.—The Council of the State Medical Society has appointed committee members for the year 1953–54, according to Dr. R. G. Arveson, Frederic, chairman of the Council. The members are as follows:

Advertising

J. M. Sullivan, M. D., Milwaukee
R. S. Baldwin, M. D., Marshfield
W. T. Casper, M. D., Milwaukee

Audit and Budget

E. M. Dessloch, M. D., Prairie du Chien, chairman
J. M. Bell, M. D., Marinette
A. J. McCarey, M. D., Green Bay
N. J. Wegmann, M. D., Milwaukee
J. C. Fox, M. D., La Crosse

Blood Bank Committee

W. D. Stovall, M. D., Madison
T. J. Greenwalt, M. D., Milwaukee
C. N. Neupert, M. D., Madison
Paul Mason, M. D., Sheboygan

Civil Defense Committee

M. J. Musser, M. D., Madison, chairman
E. P. Ludwig, M. D., Wausau
K. E. Lemmer, M. D., Madison
J. S. Wier, M. D., Fond du Lac
E. A. Bachhuber, M. D., Milwaukee

Editorial Board

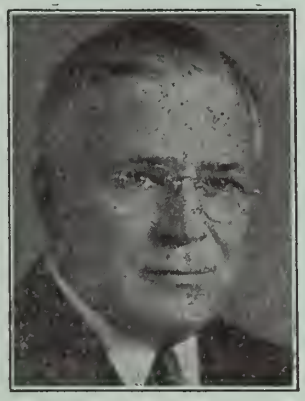
D. W. Ovitt, M. D., Milwaukee
Elwood Mason, M. D., Milwaukee
Frank Weeks, M. D., Ashland
G. A. Cooper, M. D., Madison
V. S. Falk, M. D., Edgerton

Historical Committee

H. Kent Tenney, M. D., Madison, chairman
E. M. Dessloch, M. D., Prairie du Chien
P. R. Minahan, M. D., Green Bay
E. E. Kidder, M. D., Stevens Point
N. J. Wegmann, M. D., Milwaukee
E. H. Ackerknecht, M. D., Madison
G. Kasten Tallmadge, M. D., Milwaukee

Military Medical Service

F. L. Weston, M. D., Madison, chairman
M. J. Musser, M. D., Madison



DR. R. G. ARVESON

J. M. Sullivan, M. D., Milwaukee
M. H. Steen, M. D., Oshkosh
O. G. Moland, M. D., Augusta

Commission on State Departments

T. W. Tormey, Jr., M. D., Madison, chairman
J. D. Steele, M. D., Milwaukee
R. F. Purtell, M. D., Milwaukee
T. L. Tolan, M. D., Milwaukee
R. G. Piaskoski, M. D., Wood
J. A. Schindler, M. D., Monroe
E. H. Pawsat, M. D., Fond du Lac
H. W. Carey, M. D., Lancaster
H. A. Sincock, M. D., Superior
E. D. Schwade, M. D., Milwaukee

Veterans Medical Service, Operating Committee

J. S. Supernaw, M. D., Madison, chairman, 1956
O. A. Dittmer, M. D., Ripon, 1955
Maurice Hardgrove, M. D., Milwaukee, 1954
W. A. Fischer, M. D., Frederic, 1957
J. L. Moffett, M. D., Platteville, 1958

Interim Committee

J. M. Bell, M. D., Marinette, 1956
J. C. Fox, M. D., La Crosse, 1955
R. E. Galasinski, M. D., Milwaukee, 1954

Ex officio members of this committee include Dr. Arveson, chairman of the Council; Dr. S. E. Gavin, Fond du Lac, chairman emeritus; Dr. J. C. Griffith, Milwaukee, president of the State Medical Society and Dr. H. Kent Tenney, Madison, president-elect.

Commission on Prepaid Plans

E. M. Dessloch, M. D., Prairie du Chien, chairman, 1955
Robert Krohn, M. D., Black River Falls, vice-chairman, 1956
N. A. Hill, M. D., Madison, treasurer, 1955
J. T. Sprague, M. D., Madison, assistant treasurer, 1956
H. E. Kasten, M. D., Beloit, 1956
W. T. Casper, M. D., Milwaukee, 1956
R. E. Garrison, M. D., Wisconsin Rapids, 1954
K. H. Doege, M. D., Marshfield, 1954
Milton Finn, M. D., Superior, 1954
J. S. Supernaw, M. D., Madison, 1954
H. A. Aageson, M. D., Oconto, 1954
R. M. Moore, M. D., Frederic, 1954
C. G. Reznichek, M. D., Madison, 1954
W. C. Stewart, M. D., Kenosha, 1955
Richard Foregger, M. D., Milwaukee, 1955
H. B. Christianson, M. D., Superior, 1955
G. W. Carlson, M. D., Appleton, 1955
P. B. Mason, M. D., Sheboygan, 1955
Ex officio: President.

Numbers in all cases indicate the year a committee member's term expires.

EAU CLAIRE AREA TO BE SURVEYED

Eau Claire, April 1.—Eau Claire county is one of 91 areas of the United States which will be surveyed in regard to family medical costs by the National Opinion Research Center of the University of Chicago, in May.

The survey, which will be made by specially trained interviewers, is supposed to provide comprehensive information on total costs and distribution of medical care and on the effectiveness of voluntary insurance plans now in operation.

Twenty households in the city and ten in rural areas will be surveyed. The study is being financed by the Health Information Foundation, a non-profit organization.

Social Security Study Probably Precludes Expansion of Coverage by This Congress

Washington, April 10.—One of the greatest tasks undertaken by the Eisenhower administration is a thorough overhauling of the colossal Social Security system. This study is expected to prevent any major expansion of coverage at this session of Congress, according to *Insurance Economics Surveys.*

In less than two decades the system has grown until it represents 26 billion dollars in reserve funds with approximately 17 million beneficiaries who in 1952 received payments of nearly 9 billion dollars.

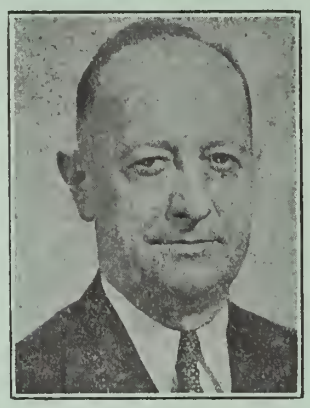
Not True Insurance

Social Security's old age and survivors insurance is, however, not a true insurance system. It does not operate on the principles of private life and annuity insurance companies. Its so-called reserve fund is not a true reserve, but only a political illusion, with the real insurance provided by the taxing power of the federal government. As long as the government can raise the required taxes, the insured old people will be assured of receiving their pensions. What they and their employers are actually doing is advancing their payroll taxes for the expenses of government which must be paid in the end by taxes levied on all the people.

Since it is estimated there may be 20 million old age beneficiaries receiving approximately 13 billion dollars in benefits 50 years hence, and since payroll taxes to cover are due to increase until double the present rate, there are apprehensions that the total effect on the nation's economy may be very damaging.

Sub-Committee Studies

For this reason, the inquiry has been instituted. It has been taken over by a sub-committee of the house ways and means committee headed by Rep. Curtis (R., Neb.). This group will make a comprehensive study of the Social Security problem. One of the questions is whether Social Security has been developed under the New Deal into a guarantee of a scale of living that for many people destroys the incentive for thrift and encourages the attitude that "the world owes me a living." Far reaching changes to place the system on a sound economic foundation—possibly a pay-as-you-go basis—will be considered by the Curtis sub-committee.



DR. W. S. MIDDLETON

DR. MIDDLETON ON ADVISORY COUNCIL

Madison, April 10.—Dr. William S. Middleton, dean of the University of Wisconsin medical school, has been appointed to a six-man Civilian Health and Medical Advisory Council which replaced the Armed Forces Medical Policy Council on April 1.

Dr. Melvin A. Casberg, who served as chairman of the now defunct committee during the past year, has become an assistant to the Secretary of Defense with responsibility for all health and medical affairs in the defense department. He reports directly to Secretary of Defense Charles E. Wilson.

The six-man council will act in an advisory capacity to Dr. Casberg. Two new members besides Dr. Middleton are Dr. Dwight L. Wilbur, Stanford University and Dr. Anthony J. J. Rourke, president of the Hospital Council of Greater New York. Other members, reappointed from the former council, are Drs. Isidor S. Ravdin and Alfred R. Shands, Jr., and James P. Hollers, D. D. S. No branch of the armed services is represented on the new council.

Former Reservists Must Register If Not Yet 50

Washington, April 10.—Medical reserve officers whose commissions expired by April 1, 1953, and who are not yet 50 years of age, must register with Selective Service as required by Public Law 779.

It may not be generally understood that reserve commissions automatically expired as of April 1 if they were dated prior to April 1, 1948. A medical reserve officer who applied for reappointment in the Reserve Corps prior to April 1, 1953, need not register.

Commissions dated later than April 1, 1948, expire automatically five years from the date of appointment, unless the holder applies for extension. All reserve officer commissions after July 9, 1952, are for an indefinite term. This is as a result of legislative action of that date under which the Army and Air Force realigned their reserve structure in conformity with regular Navy and Marine Corps policy. Such commissions can only be terminated by resignation, discharge or retirement.

Reservists whose commissions have expired and must now register may do so by calling in person at the nearest local draft board and presenting themselves as special registrants under the doctor draft.

New York Continues to Refuse Chiros Licenses

New York, April 2.—Through an intensive public education campaign, the public and professional relations bureau of the Medical Society of the State of New York helped to kill a chiropractic bill in New York state. The state senate rejected the bill by a vote of 32 to 24, thus keeping the Empire state one of four in the nation which does not license this group of cultists.

The medical society's campaign involved the appointment of a special Citizens' Health Education Committee headed by Dr. J. Stanley Kenney. This committee organized 61 sub-committees, using as many county societies as basic groups, but including lay personnel. They distributed 500,000 pamphlets about cultism over a period of five months.

State Laboratory of Hygiene Dedication Ceremony, Madison, February 28, 1953

Excerpts from the Afternoon Program

Dr. C. N. Neupert, State Health Officer: We are gathered here today to dedicate a new State Laboratory of Hygiene building which marks a big step forward for healthier living for all the people of this state.

During the 50 years that the state laboratory has been in existence, diphtheria has been practically eliminated. Earlier all of the children in family after family were wiped out by that disease. This laboratory, along with the branch and cooperative laboratories under its technical guidance, identified the bacteria from patients and contacts so that attending physicians and public health officers could apply specific curative and control measures. Though time does not allow me to enumerate the various catastrophes that were common and terrifying a few years ago, special mention of typhoid fever is in order. Our last major outbreaks of typhoid occurred in 1929. By cleaning up our water supplies, especially in the cities, and by treating our sewage, we have come to the point when most of our people are no longer even aware of the potential danger of typhoid. These advances would not have been possible without the essential laboratory services.

Now we have a new laboratory and now we look forward to new conquests only dreamed of and hoped for during the years. As former communicable disease hazards come under control, we are faced with new threats. Among these are the virus diseases—influenza, pneumonia, diseases involving the central nervous system, and other upper respiratory infections suspected of being caused by viruses that spread through our communities. At long last we can study, and I hope eliminate, the intestinal disturbances that plague the people in some parts of the state.

Our laboratory, and by "our" I mean all of us, not just the State Board of Health, is a shining example of cooperative effort between state and federal governments and between two state agencies, the University of Wisconsin and the State Board of Health. There are many, many capable people to whom all of us are under obligation for this new service center. You will better appreciate how well they have planned and how hard they have worked when you see it first hand during the inspection tours following these dedicatory exercises.

Mr. A. Matt Werner, president of the University of Wisconsin Board of Regents: It is with a real sense of accomplishment that we dedicate the new Wisconsin State Laboratory of Hygiene. One of the measures by which we Americans as a nation have gauged our program during the years is the rise in our general level of health. We know, for example, that many of the diseases that were serious concerns not more than 20 years ago have yielded in a remarkable manner to the modern medical worker and the new materials he has at his disposal. We know that many of the diseases that we ourselves had in past years and that we saw our children have not so long ago now occur very infrequently. I have been told that the mere appearance of some

The new building for the State Laboratory of Hygiene on the University of Wisconsin campus.

of these diseases that were once so common is now virtually cause for a general medical school convocation.

But the fact that we often tend to forget is that the firing line of medical progress is in buildings such as the one we are dedicating today. The efficiency of a medical firing line, or any other kind, is limited by the equipment available and the people available to man that equipment. Regarding the latter, we have no cause for concern. We are justly proud of the research and service achievements of Wisconsin scientists and I am sure I speak for the people of the state when I say that it is with mixed hope and gratitude that we turn this additional piece of equipment over to them under the able leadership of Doctor Stovall. I was astounded to learn that each year the State Laboratory of Hygiene makes over 200,000 individual tests for the diagnosis of diseases such as typhoid and tuberculosis and of the agents of disease dispersal such as drinking water, milk, and ice cream.

The laboratory reports reveal that there is still a need for the control of diphtheria, scarlet fever, and smallpox. Some of our old enemies are still with us and we see the wisdom of maintaining the old fortifications while we push forward against infantile paralysis, cancer, heart disease, brucellosis, influenza, occupational diseases, and the ailments of old age. It is important that as many of the handicaps and obstacles to the effective operation of public health laboratories be removed as it is possible for us to remove. For they will become even more important in the future than they are today, if we are to retain our leadership of the free and civilized world.

President E. B. Fred of the University of Wisconsin: The dedication of a new and much needed building is always a happy occasion. The dedication of a new State Laboratory of Hygiene is particularly happy, for in a very real sense this building is a major milestone in the medical progress of the state. It marks the beginning of a new era in the history of Wisconsin medicine.

To those who have been working in quarters entirely inadequate for the job they were asked to do, it marks the end of a dream and the beginning of a new and more efficient program of health for the people of Wisconsin. Expanding programs of diagnosis, intensified studies of infectious diseases, and improved health for the citizens of Wisconsin will result from the new building which we are dedicating this afternoon. The people of Wisconsin are as enthusiastic as Doctor Stovall and his associates about the promise that the future of the new Laboratory of Hygiene affords. Health is our basic resource. The health of Wisconsin citizens has been guarded wisely and well by the State Board of Health and the State Laboratory working with the hundreds of physicians who use the facilities of the laboratory. But our population is growing, our life is becoming more complex.

Since the days of President Charles R. Van Hise, the University of Wisconsin has consciously molded its activities according to three general concepts. First, education for life and work in democracy. Second, research for the betterment of mankind; and third, service accomplishments which carry the ideas and the benefits of the first two concepts to people far beyond the campus of the University, to the very boundaries of the state and the nation. To my mind, no organization provides a better example of the combination of all three of these concepts than the State Laboratory of Hygiene. The laboratory assists in the professional training provided by our medical school. It has carried on in the past what research it could with the space available. But its major role has always been service to the people of Wisconsin. The success of the state's program of prevention and control of communicable diseases can be attributed in a large part to the diagnostic service of our public health laboratories. Their past success makes us confident that some day we will meet the challenge of tuberculosis, the virus diseases, and the degenerative diseases.

Dr. J. C. Griffith, president of the State Medical Society of Wisconsin: The role of the State Laboratory of Hygiene in the practice of medicine in Wisconsin is very much appreciated by Wisconsin physicians. We have long realized the importance of the laboratory in the health of the people of Wisconsin. We realize its great value to the State Board of Health in making the health of the people of Wisconsin better in every way by the control of water supplies, milk, ice cream, sewage disposal, industrial waste, infectious disease, epidemics, and venereal disease. But closer still to us as physicians is the role the laboratory plays in our everyday practice. By making special blood and urine examinations for malignancy, it enables us to take better care of our patients. These tests are also available to the small community or community hospitals where a pathologist is not available for that study. The medical profession of Wisconsin, I can truly say, is appreciative of the cooperation that the State Laboratory of Hygiene has given us. We consider this laboratory a helpmeet and an ally in our fight against disease. And I think that that very fact is a tribute to those who sponsored it, to the Board of Regents, to the State Board of Health, and especially to Doctor Stovall and his staff.

Dean W. S. Middleton of the University of Wisconsin Medical School: Interest in personal hygiene and public health is by no means new. We have only to go to the Bible to discover that the health laws of Moses are just as valid today as they were when he wrote them. In 590 B. C., with the construction of the Aqua Magna, we have the beginning of real municipal distribution and disposition of water. In 312 B. C. the first aqueduct was constructed in Rome. Turning to British civilization, we find that it took the great plague of 1665 and the fire of the succeeding year to produce any written law on pub-

lic health. Our own national activity dates from 1879, with the establishment of the National Board of Health, which led to the public health service and the marine service. Now we have the National Institutes of Health and all of the activities coming under the Federal Security Agency.

The circumstance that motivates a country to work for public health legislation must, of course, be humanitarian. From an idealistic standpoint, we wish that this might be enough, but we realize that the economic impact of illness and the economic advantage of health are also major considerations. Carried from that point there is fear, and fear will motivate in a passive sense where the more active and altruistic ends may not avail. Lastly, there is a patriotic motive—the realization that only a strong and healthy nation can resist foreign aggression.

It is entirely proper, as representatives of the medical profession, that we should take some pride in the accomplishments of the past. There has been the conquest of certain bacterial diseases. I was pleased and quite satisfied to read in the morning paper that Doctor Stovall would not have us complacent in our advances but rather realize that diseases such as scarlet fever, diphtheria, and tuberculosis are just bending, not broken. Accordingly, the pressure must be maintained so that in the end they will be vanquished.

As we are confronted with the training of new men in medicine, men to carry the advance further, we must emphasize not only the triumphs of the past, but the challenges of the future. In this new temple of health, and temple of health it is because it promises to bring an increased measure of health to the state, we must find not only the instruments and the technics for improved health, but also the personnel.

As you know, the State Laboratory of Hygiene has been a guest in the home of the University for 50 years, since 1903. The laboratory has participated in every measure of education and every measure of training that have been a part of the program of the Medical School.

In the leadership of Dr. W. D. Stovall there has been inspiration, there has been vision, there has been most of all public service. There have been times when I have wondered into how many parts Bill Stovall could divide himself. But always, like the bread on the waters, his efforts have brought back increasing returns.

With the fine facilities of this new laboratory, I know that its work will go forward at an accelerated pace.

Dr. L. A. Scheele, surgeon general of the United States Public Health Service: There is little I can add to the story of this new Wisconsin State Laboratory of Hygiene. It is not surprising to find that it has some unusual features and an unusual history. Wisconsin is known far and wide as the home of people who are not afraid to have new ideas or to put those ideas into practice in discharging their responsibilities as citizens. This great University

Congratulations are received by Dr. W. D. Stovall, left, director of the State Laboratory of Hygiene, from Dr. J. C. Griffith, president of the State Medical Society, at the testimonial dinner given by the Society for Dr. Stovall the night of the dedication of the new building. Also pictured is Mrs. Stovall.

with its outstanding Medical School and Hospital is one of those new ideas. This Laboratory and the public health program it serves also are Wisconsin ideas in practice.

Early in the last quarter of the nineteenth century, while bacteriology was still a new-born science, many of the states established boards of health. Soon thereafter the boards realized that laboratory services would be the foundation of any positive methods for the control of communicable diseases. At that time there were very few medical schools worthy of the name, and of these, only one or two had introduced research and teaching in bacteriology. By the turn of the century, therefore, a good many state boards of health had set up state laboratories in the health department, independent of medical schools.

And here we arrive at the unusual history of the Wisconsin State Laboratory of Hygiene. For with rare vision, Wisconsin in 1903 placed its state laboratory right on the campus of the University and tied it firmly to the School of Medicine. About 10 years later, the State Board of Health and the University brought Doctor Stovall to the laboratory. In this action, too, Wisconsin showed rare vision, for Doctor Stovall was a man completely in accord with the new idea of linking the functions of a state laboratory of hygiene with the functions of a university medical school, and he was a man who would generate ideas himself.

We have concrete proof that the basic plan was conceived by men of wisdom and courage. That has been the situation in Wisconsin, where the combined interests of the medical profession, the Board of Health, the University, and the state legislature have crowned the efforts of Doctor Stovall and his staff with the construction of this splendid new

building and with statutory expansion of their program.

The hopes of the Board of Health, the University, and the laboratory staff can be realized with the excellent facilities now available. I am sure that inspection of the new laboratory will make you agree that modern scientific technics require a far more elaborate and complex set-up than the type that served the purposes of the nineteenth century pioneers in bacteriology. Let me read you a description of a hygienic laboratory set up in 1887.

"In August a bacteriology laboratory was established at the port of New York. It is situated at present in one of the rooms of the main hospital building. The different apparatus was modeled after those used in the laboratory of Doctor Koch of the Imperial German Health Board, and is supplied with Zeiss's latest improved microscope objectives and microphotographic apparatus. Different animals are kept on hand for experimental purposes. Additions have been made from time to time until a very complete plant of apparatus exists for analysis and bacteriological investigations."

Everything was in one room, mind you, and the laboratory staff consisted of one man. Yet this was the beginning of the old hygienic laboratory which today is the National Institutes of Health of the Public Health Service. In the intervening years, there have been innumerable occasions when the Wisconsin State Board of Health, its Laboratory of Hygiene, and its University School of Medicine have worked as partners with the Public Health Service on problems of mutual concern. We in the Service, therefore, are particularly happy that our colleagues in the laboratory are celebrating the dedication of their new building.

The humble beginnings of medical and public health research remind us that bricks and mortar and "a very complete plant of apparatus" are useless without the men and women who staff the laboratories. People outside the scientific world seldom realize what demands are made on the people inside. I wonder, for example, how many Wisconsin citizens realize that the staff of their State Laboratory of Hygiene is performing, on the average, 17,000 tests per worker per year. Experts in these matters consider this a very heavy load. So while you are congratulating yourselves on giving your laboratory staff such fine facilities, do not forget that they cannot take on the many new programs you are planning for them without more co-workers and, I may add, do not forget that even the opportunity to work in such superior quarters may not offset the personal sacrifices that relatively low salaries demand. There are many state laboratories today that have been unable to command the interest and dedication of well-qualified personnel because neither the programs nor the facilities challenge the ablest young scientists. There are still more who have lost their best personnel to other employers because the state service did not offer reasonably adequate compensation.

I am sure that the people of Wisconsin will not allow their State Laboratory of Hygiene to fall into either of those categories. The splendid building we are dedicating this afternoon and the programs to be pursued here will command the interest of able scientists for years to come. And since Wisconsin has evidenced a faith in the value of the scientific work done here, that faith will meet the other needs so that this State Laboratory of Hygiene and its devoted staff may have the greatest range of usefulness to the people of Wisconsin.

Testimonial Dinner

Doctor Scheele: Doctor Griffith, Doctor and Mrs. Stovall, distinguished guests, ladies and gentlemen.* I cannot tell you how really pleased I am and what it means to me to join with the Society tonight in honoring Doctor and Mrs. Stovall.

You touched on one little part of my not-so-checkered past—the days when I was working in cancer, and that reminds me that I owe a great personal debt to Doctor Stovall. It was in 1937 that I first met Doctor Stovall here in Wisconsin, and learned to know him quite well. He gave me good counsel on some of the things that I was trying to do in the field of cancer control.

In coming back to Wisconsin, I am also reminded of the fact that another of your distinguished citizens, the late Frank B. Keefe of Oshkosh, helped in the development of another laboratory — our National Institutes of Health of the Public Health Service in Washington. Without the support of Frank Keefe, the National Institutes of Health would not be moving into the new phase of research which it will enter in a few months with the opening of the new Clinical Center.

Now, let us turn to the man we are honoring tonight. If a man from Mars were to look in the World Almanac for memorable dates in the year 1887 he would read that an important treaty was signed in Europe, that in China the Yellow River had gone on another rampage taking nearly a million lives. But he would find no mention of the New World.

---

* Seated at the speaker's table with Dr. W. D. Stovall, director of the State Laboratory of Hygiene, and Mrs. Stovall were Dr. R. G. Arveson, chairman of the Council of the State Medical Society; Dr. G. D. Cummings, director of the Michigan State Laboratory of Hygiene; President E. B. Fred of the University of Wisconsin; Dr. S. E. Gavin, president of the Wisconsin State Board of Health; Dr. Harold Granning, regional medical director of the United States Public Health Service; Dr. Joseph C. Griffith, president of the State Medical Society; Dr. C. N. Neupert, Wisconsin State Health Officer; Dr. L. A. Scheele, surgeon general of the United States Public Health Service; Dr. H. J. Shaughnessy, deputy director of the Division of Laboratories of Illinois; and Mr. A. Matt Werner, president of the University of Wisconsin Board of Regents.

Doctor Griffith served as master of ceremonies for the program which followed the testimonial dinner.

Dr. Leonard A. Scheele, surgeon general of the United States Public Health Service, speaks at the dedication of the new State Laboratory of Hygiene. Left to right, President E. B. Fred of the University of Wisconsin; Dr. Scheele; A. Matt Werner, president of the University's Board of Regents; and Dr. C. N. Neupert, state health officer.

Nevertheless, 1887 was a memorable year for public health in the United States. In Longtown, Mississippi, on October 31, Mrs. Joseph Pendleton Stovall gave birth to a son—William Davison. That same month, a young doctor on Staten Island, New York, looked through his brand new microscope and decided that he had succeeded in isolating the cholera vibrio for the first time in the New World.

The birth of little Bill Stovall began a lifetime of study and achievement, of bold pioneering and distinguished service in the fields of bacteriology, pathology, and public health. The work of young Doctor Kinyon marked the beginning of scientific research in the United States Public Health Service.

For this reason it gives me special pleasure to bring to our distinguished guest of honor, Doctor Stovall, the congratulations and affectionate regards of his many friends in the Public Health Service. We salute every memorable year of his life—especially this crowning year in which his dream of a new laboratory has come true.

Some years elapsed after 1887 before the future director of the Wisconsin State Laboratory of Hygiene and the Public Health Service became aware of each other's existence. But they were golden years, both for the young scientist and for man's conquest of many infectious diseases. Bacteriology in those days was still a new-fangled science—bacteriologists were commonly referred to as "bug doctors." The Public Health Service has listed some famous "bug doctors" in its time and we are proud that Doctor Stovall spent a brief period at the Marine Hospital in New Orleans while winning that title in his postgraduate study of tropical medicine and hygiene. We are sorry that he did not sign up with us for the duration. Our loss is Wisconsin's immeasurable gain.

A man has to have uncommon vision to see on the horizon a need, at the moment no bigger than a cloud the size of a man's hand, but destined to grow progressively with the passage of years. To translate his vision of how to meet such a need into reality, he has to have uncommon perseverance and valor. Doctor Stovall has had these virtues in uncommon measure.

The Wisconsin State Laboratory of Hygiene was one of the first laboratories in the country to provide clinical pathology services. Even now there are only 20 which do this kind of work. The introduction of clinical pathology and the high quality of work at the Wisconsin laboratory are among Doctor Stovall's many contributions. Another is his perseverance in making the state laboratory a teaching as well as a service and research institution. When Doctor Stovall came to Madison, progressive Wisconsin had already placed its laboratory in its great University Medical Center. But his concern, his efforts, and his influence have been the chief factors in furthering the desirable synthesis of teaching, research, and service which distinguishes the University of Wisconsin Medical Center and the Wisconsin state health program.

Underlying the accomplishments which are symbolized by the fine new laboratory that was dedicated this afternoon, there has been throughout Doctor Stovall's career the good physician's concern for the individual patient. Yet, like most public health physicians, he seldom has the intimate satisfaction of watching the seriously ill person recover under his care. For him, swift and accurate service to the attending physician must be his sublimation; in a lifetime of service, his reward—to see the death rate from this or that disease come slowly down.

A motivating force like his has brought about the great developments in medicine and public health through the centuries. Laboratory technics, instrumentation, and facilities have become vastly more effective—and more complex. But although they extend our range of competence, they cannot take the place of the mind and the spirit. It is because Doctor Stovall has been so dedicated to his task that we, and his friends everywhere, wish him many more memorable years of service to mankind.

Doctor Stovall: Joe, Mr. Chairman, Mr. President, honored guests at this table, and friends in the audience.

The expressions of my friends today in the dedication exercises of the State Laboratory of Hygiene building make me wonder if I am who I think I am. A nursery rhyme tells us that there was an old woman who fell asleep on the highway and when she awoke she had been changed so much that she was not sure who she was. "But," said she, "if I am who I think I am, I have a little dog at home who will know me." If *I* am who I think I am, I have a little family at home who will know me. I am also reminded of the little boy who, during a eulogistic oration on the life of his father at the funeral exercises, asked his mother, "Ma, is he talking about Pa?" This is a rare occasion, and rare occasions

afford rare opportunities. I would be remiss in my duty if I accepted all of these compliments for the things that have been done without telling you that I did not do them myself and alone. I have had help and cooperation.

The new building for the Laboratory of Hygiene is not the result of my effort alone. It is not my laboratory. It is the result of the united effort of many and grew out of the concept and conviction that we live by science and that we in Wisconsin did not have adequate facilities to cope with the challenge of disease.

As you have heard from Doctor Griffith, the State Medical Society has honored me in many ways. Every one of them I have sincerely appreciated and am most thankful for. When they gave me the Award of Honor from the Council of the State Medical Society, the highest honor that the Society can confer upon one of its members, and my friend Steve Gavin hung that medal around my neck, I considered it to be the greatest honor that could come to me. I still so consider it.

Then I was made president of the State Medical Society and it gave me an opportunity to sit on the Council of the Society and to see the objectives toward which that body of physicians was working. I had worked on committees before, but when you get to be president, you see the heart as well as the head at work. You see what is going on, you hear the debates and the discussions. The more intimate I have become with the workings of the State Medical Society, the stronger has grown my devotion to the sincere and earnest concern of the doctors of this state for the health of the people of the state. This has been a great stimulation to me. It has given me the faith and the courage to proceed with things that I would not otherwise have had the faith or courage to undertake. I have enjoyed my work every day, but it has been those with whom I have worked that have made the life so pleasant and the work so satisfying.

We have a fine heritage in Wisconsin in the accomplishments of our progenitors. They have bequeathed to us a high regard for education and wrought for us a University dedicated to the search for truth and the application of the results of this search to the improvement of living conditions of people throughout the state. They expressed this concern in the state government and created administrative departments which have been noted for honesty of purpose and skill in administration. The creation of the State Laboratory of Hygiene in 1903 to be placed on the University campus and administered through the Board of Regents with the designation that it was to be the laboratory for the State Board of Health is an illustration of their thoughtfulness and wise deliberation. Bringing basic science and applied science together for the benefit of all the people was the motivating concept behind this act of the legislature. As science has progressed, this fundamental concept is as apparent today as it was in 1903. Joint effort by these two departments of state government, the State Board of Health and the Medical School in the University, is essential to the successful application of basic science to the control and prevention of disease.

It was these concepts that urged me on in an attempt to secure better facilities for the application of modern sciences to the improvement and protection of the health of people in our state. It was the encouragement and faith, and help and support given me by Doctor Neupert and the Board of Health, by Doctor Middleton and the University Board of Regents, by the physicians and officers of the State Medical Society and last, but by no means least, by the members of the legislature. Senator Robert Robinson was one of them. I cannot name them all, but he was a great source of encouragement to me and gave me the energy and the courage to go ahead with the ideas that we were discussing. Governor Rennebohm made a great contribution. And I see another friend sitting in this room who made a great contribution, and that is my friend Bill Young. You know you cannot do these things by yourself. If the thinking is straight, men of thoughtful dispositions and earnest desires for the promotion of human welfare and the saving of human life will agree and join in an effort for accomplishments. If it is wrong, they will catch you up quickly. It is this check, it is this control, that makes the democratic way of living a success. No one tells us how to live. We determine that for ourselves. And that's the way this building has been done.

The planning of the building and what would go into it was not done by me alone. I had help. We, the staff, decided what belongs in an institution of this kind. This laboratory can be a great communicable disease center for the whole state of Wisconsin from which can emanate information and facts which can be beneficial not only to the people of Wisconsin but to people throughout the country and possibly the world. If those who have made the building possible continue their interest in the success of these purposes we need not fear failure. And Senator Robinson will agree with me that when we talked this over, these facts were all presented to the legislature. The legislature was told that if the building was granted, money would be required for increasing the staff and for purchasing necessary supplies. The building was granted.

In planning it the whole staff participated and after we knew what the size of the building would be and were told by our architects how many square feet we had on each floor, we divided the space up according to the kind of work that was to be done. This determination made, we then assigned space for the various divisions, decided upon the apparatus required for each function, and drew it in the proper position. The architects designed the building to accommodate such functions. I compliment them, particularly Mr. Rose, who planned so well for the beauty as well as the functional requirements of the building.

So, I thank you kindly for all of your compliments. I feel greatly honored, and in all humility I accept your graciousness to me. This dinner tonight is not a formal expression of greeting to me; it expresses a depth of friendship and affection that one very rarely experiences. I fully appreciate the rarity of the occasion and I am sure you recognize the depth of feeling that it arouses in me. I expect as the years go by we will be able to accomplish all the things we want to accomplish, all the things that I know we can accomplish.

The future is not built from a pattern of the past, it is what we think today that prepares us for tomorrow. The patterns that made our present culture and civilization cannot be used as patterns for future generations. If those who passed on 50 or 100 years ago should now suddenly come to life, they would be greatly surprised at what is going on. They would say that this was not patterned after what we did. But it is what they were thinking that made today possible. If we have thought correctly the building dedicated today will be a functioning instrument in tomorrow's methods for the control and prevention of disease.

It is well to reflect for a moment on the past to emphasize the change that has come about in the last 50 years. The great differences between the life of yesterday and that of today are apparent to all who contemplate them. There was a great physician who lived in this country in the latter part of the last century and the early part of this century. He was not only a great physician but also a great humanist; he was not only a great humanist but also a great scholar; he was not only a great scholar, but also a great teacher. On one occasion, in 1910, he was invited to Edinburgh to address the medical students, and he chose for his subject "Man's Redemption of Man." He was William Osler, who later became Sir William Osler and finally lived in England and taught at Oxford University. That speech in Edinburgh is as stimulating an address as anyone can read. It shows the confidence that he had in the new science. In it he predicted the future of medical practice and public health, not from the methods of his time but from the changes that would be brought about by the application of the new sicence which was just on the horizon. This new science was supported by centuries of research and investigation. These investigations came to a focus in the latter part of the nineteenth century like a sudden burst of light. New branches of science were created, the concept of the cause of disease was changed, methods and ideas concerning the spread of disease were removed from the realm of the fictitious and superstitious into the physical world, and all of this created new concepts about resistance and susceptibility to disease, methods of diagnosis, treatment, control, and prevention. It was from the knowledge of these and other new sciences that he predicted "man's redemption of man." He said, "The life of the individual is more valuable than gold."

The predictions of William Osler have been realized to a large degree. Many of the communicable diseases which were devastating and demoralizing to whole communities have been brought under control. To do this, systems for their control have been set up throughout our state and all other states in the country. These systems work day and night so quietly and efficiently that most people are not conscious of how their health is protected or that it is being protected. Now that the decimating epidemics of days past no longer occur to strike terror to the heart and mind of every individual, the need for protection is forgotten. If, however, the machinery of protection that comes through sanitation, immunization, and other technics too numerous to mention is allowed through neglect to deteriorate or lose its effectiveness, the flood gates will open again for the old enemies of mankind.

At this point we can make some predictions of our own. Many new sciences have revealed to us knowledge unthought of when William Osler gave his address on "Man's Redemption of Man." These sciences are offering to this generation and will offer to future generations new concepts, new technics, and new methods to apply to the promotion of the happiness and welfare of mankind. Unfortunately, they are also opening up avenues through which not only the life but the dignity, independence, and freedom of the individual can be destroyed. It is the job of this and future generations to find a way whereby science can be applied for the benefit of every man and to prevent it from destroying him and his free institutions. The new building for the Laboratory of Hygiene is dedicated to these purposes.

Research creates new knowledge; knowledge is the basis for new concepts and new concepts are the stimuli for new practices. Through knowledge and its application the civilization of man has been accomplished. In this way it will be improved in the future. But knowledge without the facility for applying it is sterile.

These things are not accomplished by one person unaided. The help of people of good will and interest in the lives of others is needed. The point of the whole effort, however, is lost to many people in the expression "public health." This is a general term and to too many means everybody's health except their own. To too many public health means the control of disease in the mass, and the health of the individual is lost in that concept. But the individual is the objective of all disease control and prevention measures and all health maintenance. It is through accomplishment of better health for each individual that the health of the public is improved. Public health involves masses of people, but it is attained through the individual. It is because the health of the individual and his family is so essential to our dignity as free people that public health and individual health are synonymous.

As science has progressed new concepts have been perceived, and new practices introduced to cure or prevent individual diseases, chronic as well as acute.

Out of these our understanding of preventive medicine has developed. Among the chronic diseases tuberculosis and syphilis are outstanding examples of this approach to the improvement of the health of the individual by control of the disease or, in some cases, by its cure. While the death rate in Wisconsin from tuberculosis has been reduced from 103 per 100,000 in 1908 to 9 deaths per 100,000 of the population, the total number of deaths is still high. Last year in Wisconsin, 350 people died of tuberculosis. When we consider that the 500 deaths in Wisconsin from typhoid fever in 1910 would today be evidence of gross neglect, we must look upon tuberculosis as a major problem. Because case-finding technics are greatly improved and new methods of treatment have been perfected we can look forward to the complete eradication of this disease. The surgeon with the aid of antibiotics has brought new methods of attack against this problem. When the disease is diagnosed early he can remove a small lesion and probably free the chest of the infection.

Syphilis, another one of the chronic diseases which have plagued mankind throughout history, is vulnerable to modern methods of treatment and already its incidence is decreasing rapidly.

These successes in the control of chronic diseases which were previously considered incurable have resulted from the concept of early diagnosis and prompt and adequate treatment. Cancer also comes in this category. There is much to be learned about this disease. Notwithstanding this, the State Medical Society as early as 1922 recognized the seriousness of the cancer problem and authorized the appointment of a committee to carry out an educational campaign based on the importance of early diagnosis and to replace a negative attitude of fear and despair with positive action. As science has uncovered new knowledge applicable to the cure, control, and prevention of this disease as well as others, the interests of physicians and health officers have converged.

When the American Cancer Society offered help to this undertaking, the State Medical Society welcomed it and financed their first campaign in this state to secure funds with which to conduct an educational program for the public and to aid in programs of research. In more recent years the United States Public Health Service and our State Board of Health have recognized the cancer problem and now have special divisions devoted to its control and prevention, as well as to research.

Steadily we march forward. Environmental sanitation offered the most important technics in the field of public health practices during the first part of this century. The advent of preventive medicine broadens this field of attack. We are all conjoined in the application of science for the improvement of the health of our state. "'Life is not to live, but to be well."

Thank you so much for everything you have done for me. It has been a privilege to work with and for you. It is to all of you—the State Medical Society, the State Board of Health, and the University—that I am deeply grateful for the opportunity that has been offered me. I am glad that I have lived in Wisconsin and that I have been able to be associated with a group of forward-looking people who have had the courage to act where it was clear that action was needed.

ROCKY MOUNTAIN CANCER CONFERENCE TO BE HELD JULY 8 AND 9

The seventh annual Rocky Mountain Cancer Conference will be held in Denver on July 8 and 9. As in previous years there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their ladies. There is no registration fee for this Conference.

Further information may be obtained by addressing Mr. H. T. Sethman, executive secretary, Colorado State Medical Society, 835 Republic Building, Denver, Colorado.

UPPER PENINSULA MEDICAL SOCIETY ANNUAL MEETING

Three Wisconsin physicians will speak at the annual meeting of the Upper Peninsula Medical Society, to be held in Escanaba, Mich., on Friday and Saturday, June 19 and 20. Dr. R. S. Baldwin, Marshfield, will conduct the session on internal medicine; Dr. J. A. Klieger will speak on obstetrics; and Dr. J. D. Steele, on chest surgery. Drs. Klieger and Steele are from Milwaukee.

Reservations for the meeting may be obtained by writing to the secretary of the Upper Peninsula Medical Society, Norman L. Lindquist, M. D., 205 South Tenth Street, Escanaba. Since June is a busy tourist month in northern Michigan, it is suggested that accommodations be made well in advance.

1953

Annual Meeting Announcement

New Days! Switch from Monday–Wednesday to Tuesday, October 6, through Thursday, October 8, to fit "off day" schedules of more members.

New Program! Tie-in with official meetings of several state specialty societies. Morning programs of three or four special branches of medicine running simultaneously. Wide choice of subjects! Wonderful array of speakers! See next page.

New Entertainment! Away with long-winded and serious speeches at the Annual Dinner. Instead we will have dancing, music, high-class professional specialty acts. In short, an evening of delightful entertainment for members and wives.

On Tuesday something very special: "The Story of Medicine in Art" to be presented by the Milwaukee Art Institute during meeting. Exhibit will present paintings, medical art drawings, etc., from all over the U. S. Special reception late Tuesday, followed by buffet dinner for MDs, wives, and Milwaukee Art Institute members. Speaker *(very light)* Lejaren A. Hiller, New York illustrator and photographer.

MARK THE DATES ON YOUR CALENDAR: October 6–7–8, 1953

Scientific Highlights and Guest Speakers

Tuesday, Oct. 6th: SCIENTIFIC PROGRAMS . . . New! Different!

- Special programs in these fields during morning:

  ANESTHESIA (Regular meeting of Wisconsin Association of Anesthesiology):
  John W. Pender, M.D., Rochester, Minn.
  W. O. McQuiston, M.D., Peoria, Ill.

  MEDICINE AND PSYCHIATRY:
  Joseph Aub, M.D., Boston
  David Boyd, M.D., Rochester, Minn.

  ORTHOPEDICS:
  G. E. Haggart, M.D., Boston

- LUNCHEONS (Full schedule of scientific luncheons. Your notice will reach you on July 15.)

Wednesday, Oct. 7th: SCIENTIFIC PROGRAMS

- Special programs in these fields during morning:

  CARDIAC AND PULMONARY DISEASES:
  G. A. Perera, M.D., New York
  C. K. Friedberg, M.D., New York
  W. M. Tuttle, M.D., Detroit

  OBSTETRICS AND GYNECOLOGY (Regular meeting of Wisconsin Association of OB & GYN):
  L. R. Wharton, M.D., Baltimore
  C. G. Collins, M.D., New Orleans

  PATHOLOGY (Regular meeting of Wisconsin Society of Pathologists):
  Brig. Gen. E. DeCoursey, M.D., Washington, D. C.

- LUNCHEONS (10 scientific luncheons and Marquette Alumni Association luncheon.)

Thursday, Oct. 8th: SCIENTIFIC PROGRAMS

- Special programs in these fields during morning:

  PEDIATRICS:
  O. P. Kimball, M.D., Cleveland
  Milton Senn, M.D., New Haven, Conn. (afternoon session)

  RADIOLOGY:
  Traian Leucutia, M.D., Detroit

  SURGERY:
  Robert M. Janes, M.D., Toronto
  J. Barrett Brown, M.D., St. Louis

  OPHTHALMOLOGY AND OTOLARYNGOLOGY:
  O. J. Becker, M.D., Chicago
  H. M. Burian, M.D., Iowa City

- LUNCHEONS ("Full house" with many guest speakers as leaders.)

SEE JUNE, JULY, AUGUST JOURNALS FOR DETAILS OF THESE OUTSTANDING PROGRAMS

GALE

We Really ARE *Proud!*

NUZUM

Traditionally the Council on Scientific Work directs an open letter to the membership, calling attention to the scientific programs offered in connection with the Annual Meeting. We have always had reason to feel pride in the programs offered, but we feel that this year in particular we have a most noteworthy program to offer.

On the opposite page you will note the listing of speakers and the special fields of medical practice which will be emphasized. We have speakers from far-distant points who are making themselves available for our Annual Meeting program.

We feel sincere pride in the fine program which has been prepared by Dr. J. W. Gale, other members of the Council, and representatives of specialty fields, who have been asked to prepare the program. The programs will have great variety, and will offer a great deal of material which can be translated directly into office and hospital practice.

The success of the 1953 meeting does not rest with the Council on Scientific Work, which has prepared this program. IT RESTS WITH YOU AND YOUR ASSOCIATES, who by your attendance and active participation in the discussions which are provided will make the many fine speakers feel their contributions are of value to our members.

Sincerely yours,

Thomas O. Nuzum

T. O. Nuzum, M.D., Chairman
Council on Scientific Work

Special Demonstrations and Scientific Exhibits:

Each day, from October 6 through 8, special teaching programs in these fields will be presented from 9:00–10.00 a.m.:

1. OBSTETRICS & GYNECOLOGY: Movies and manikin demonstrations on special problems related to obstetrics and gynecology. Problems arranged by Wisconsin Society of Obstetrics and Gynecology.
2. FRACTURES: Proper application of casts and special technics to secure best results. Programs arranged by Wisconsin Society of Orthopedics.
3. CEREBRAL PALSIED CHILD: Demonstration with use of children of technics used to evaluate function and to improve movement. Programs planned by Wisconsin Association for the Disabled and the Milwaukee Cerebral Palsy Clinic.
4. GROSS PATHOLOGIC TISSUE: Every day demonstrations and lectures on significant pathology, by members of the Wisconsin Society of Pathology.
5. ANATOMIC DISSECTIONS: By Department of Anatomy, Marquette University Medical School. Emphasis will be on the position of the spinal needle in a lumbar puncture and the anatomic landmarks and hazards of a tracheotomy.

Annual Meeting Entertainment

GOLF: On October 5, the day before the scientific programs begin, the annual golf tournament will be held at North Hills Country Club, with tee-off in the late morning or early afternoon, and dinner and awards (and lots of fun!) that evening. This is a big social event, so get in on it by sending your reservation to Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee.

Two Events For MDs & Wives

ART SHOW: The Milwaukee Art Institute is presenting an outstanding collection of paintings from all parts of the country under the title "The Story of Medicine in Art." On Tuesday, October 6, at 5:30 p.m. doctors and their wives will be guests of the Milwaukee Art Institute at a reception and special showing of the exhibit. At 7:00 p.m. doctors, their wives, and members of the Milwaukee Art Institute will gather at the Pfister Hotel for a buffet dinner, to be followed by a light talk by the internationally famous photographer and lecturer, Lejaren A. Hiller, New York City. This is one of the most outstanding social and entertainment programs ever provided in connection with the Annual Meeting, and it will be necessary to limit attendance, so advance reservations are urged. *You will receive a special notice on this in connection with your luncheon notice on July 15.*

A Different ANNUAL DINNER:

Away with the long "stuffed shirt" speeches . . . away with the more serious side of life! The Annual Dinner this year will be strictly a social affair and will feature:

DINNER DANCING: Steve Swedish and his orchestra will furnish the music during the dinner, and those who wish to cut a rug between courses may do so.

ENTERTAINMENT: Because so many wives have lamented the inability to accommodate women as well as men at the "Smoker," we are providing this type of program for the dinner meeting. A full hour and a half of professional singing, novelty acts, and specialty dancing. We anticipate an early sell-out, so advance reservations are urged. *You will receive a special notice on this in connection with your luncheon notice on July 15.*

Watch For More News:

The next several issues of the *Journal* will carry further details of the Annual Meeting. Also, be sure you do not overlook the special mailing on July 14 (which should reach you on July 15) in the form of a brochure outlining all of the scientific luncheons. Participation to each is limited, so prompt reservations are urged.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 MAY 1953 Number 5

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Boy
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point

R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Modison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'— 1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Dr. Neupert, a Refreshing Choice

Wisconsin is pleased, but not surprised, that its State Health Officer Dr. Carl Neupert was chosen to be an adviser to the United States Government delegation at the World Health Assembly in Geneva, Switzerland, this month. We believe his presence, and others, on the American delegation *will* be a boon to this agency of the United Nations which has earned some reputation for playing politics with health on an international scale.

The Wisconsin State Board of Health has come to enjoy a close, friendly working relationship with the medical profession that is the envy of the 48 states. Doctor Neupert and the seven other members of the Board have a keen sense of the problems and thinking of the profession that is indispensable to the establishment of essential public health services in their proper place within the framework of private and public efforts to assure good health for all.

The World Health Assembly is the supreme legislative body of the World Health Organization (WHO), a specialized agency of the U.N. While its commendable programs to establish world wide biological standards, sanitary regulation, and communicable disease control will benefit all mankind, its dangerous dabblings at international treaties for minimum standards of government-provided health care benefits are quite another matter. Undoubtedly this trend was fostered by the bureaucratic machinations of the Truman–Ewing regime.

President Eisenhower's appointments, reflecting the recommendations of Mrs. Hobby, will show America's other face to Europeans and Asiatics. By now they are all too familiar with a certain few of Ewing's insipid representatives of free enterprise who often attempted to block out of view the more noteworthy members of our past delegations.

The selection of Doctor Neupert and men of similar caliber is indeed refreshing. The U.S. Government can rely on their experience and wisdom to raise the deliberations to new stature.

The New York Meeting

American Medical Association policy in the making is one of the many attractions of the 102nd annual meeting of the association in New York City, June 1–5. Two proposals are almost certain to occupy a large portion of the time of the House of Delegates —one dealing with fee splitting, the other with the care of veterans' non-service-connected disabilities by the Veterans Administration.

Drs. S. E. Gavin, Fond du Lac; W. D. Stovall, Madison; and J. C. Griffith, Milwaukee, will be Wisconsin's delegates to the meeting. Sessions of the House begin at 10 a.m., Monday, June 1, and will probably last through Thursday.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

. . . . THE PRESIDENT'S PAGE . . . .

THE President's Page this month takes the form of a Washington column. Each year at the time of the meeting of the National Chamber of Commerce, representatives of your Society, together with business men of the state, are given the opportunity to meet our senators and congressmen and discuss our problems. This privilege comes through the Wisconsin Chamber of Commerce, of which we are a part. Wisconsin is the first state to have organized medicine represented, and others have followed suit. The senior delegate to the AMA, the chairmen of the Committee on Public Policy and the Commission on State Departments, and I made the trip.

When you meet and talk with Wisconsin's congressmen, collectively or individually, in their offices or the halls of Congress, you cannot help feeling proud of the caliber of the men who represent us. Considering the small financial reward and the uncertainties of a political career, they appear to be standouts without exception.

A visit to the office of the senior senator showed him to be cordial and entertaining. As chairman of the Committee on Foreign Relations he is an important man in this Congress.

The offices of the junior senator seemed the busiest in Washington. There was a battery of secretaries, some with a telephone receiver at each ear. The senator himself appeared to be just as busy and, from the physician's viewpoint, working too hard. His friends seem to love him with a great amount of zeal and his enemies dislike him with no less degree of feeling.

We met the Vice President in his office beneath the huge crystal chandelier, removed there from the White House by Theodore Roosevelt, who said that the tinkling of the prisms and the pendants would keep the vice president awake. This one doesn't need it.

The high point of the trip was an interview with the new Secretary of Health, Education, and Welfare, Mrs. Oveta Culp Hobby. She is fully as smart as she appears. Her statement that her department intends to promote rather than provide the welfare of the American people and that the budget could be trimmed without losing any essential services should dispel the concern that exists in some quarters.

While it would seem that no one is quite as welcome in Washington as constituents who have no personal wants, one is impressed by the stature and dignity that medicine has attained in the national picture. A visit to the AMA office shows a staff cramped for space but operating with excellent efficiency. Each bill possibly relating to health is read and analyzed; it is indexed and cross-indexed as to provisions and hearings. Each week the membership is informed by bulletin on the status of each measure. Awareness of situations as they develop is necessary if the AMA is to fight successfully for the best in health for the nation. The human or personal touch to gain the ear and the confidence of the legislators is important too. We, you and I, and our colleagues make up the AMA. When we criticize the AMA we criticize ourselves. This is good, but let us keep our criticism constructive.

J. C. Griffith M.D.

Childhood constipation deserves treatment which gently restores normal peristaltic movements; drastic elimination cannot permanently correct the condition and may be harmful to the child.

ROLE OF METAMUCIL® IN ESTABLISHING PROPER BOWEL HABITS IN CHILDREN

Metamucil's bland, demulcent bulk is a physiologic way to manage bowel dysfunction in youngsters.

Metamucil does more than merely clear the constipated bowel. When taken with adequate amounts of water, Metamucil's hydrophilic colloid has a proved corrective effect on the child's misfunctioning intestines. Use of Metamucil early in life assures a natural method of elimination and helps guard against formation of the "laxative habit" in later years.

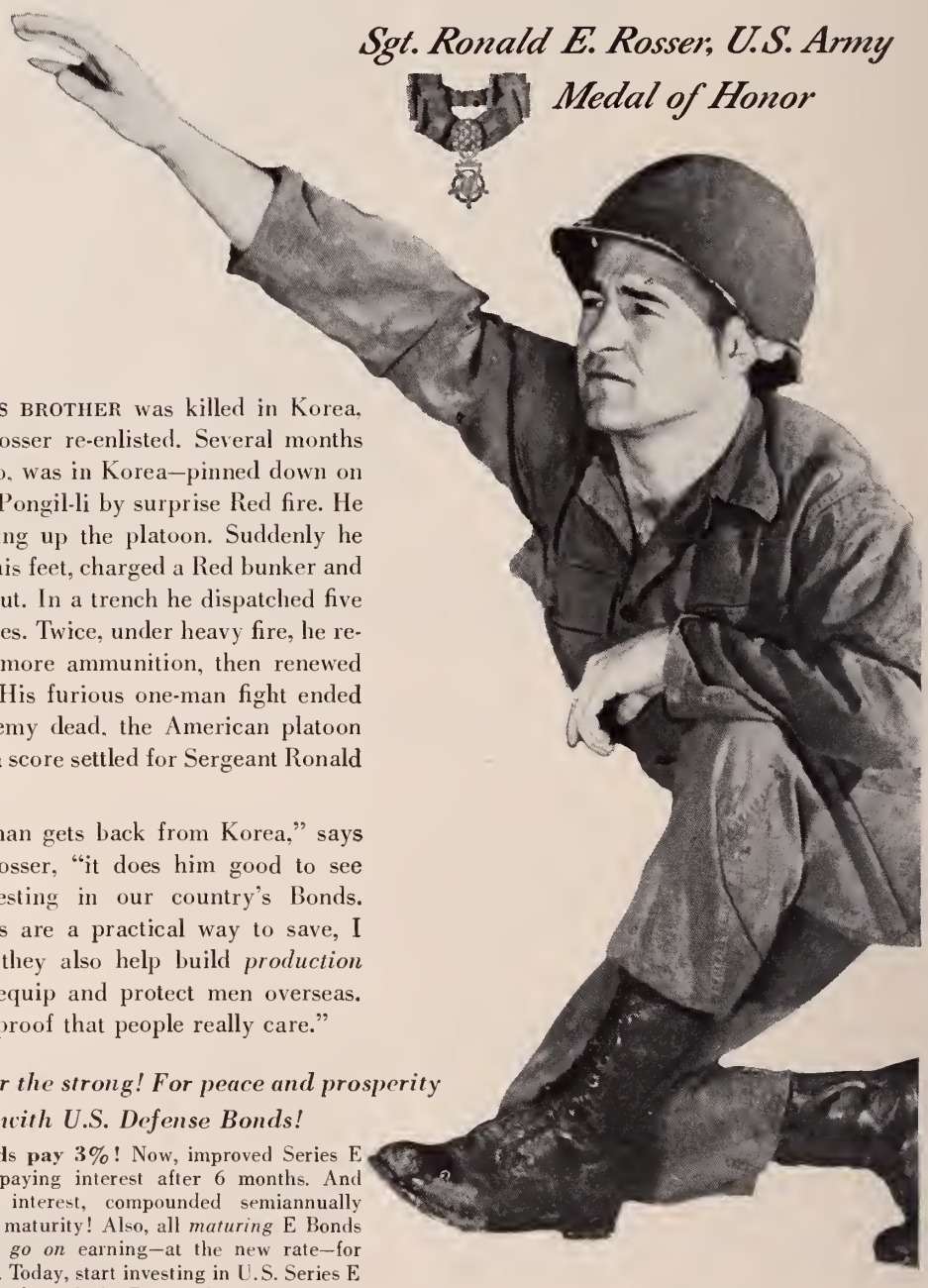
Mixed with fruit juice, milk or the child's favorite beverage, Metamucil provides a gentle, corrective stimulation to peristalsis. There is never a "rush"—never a weakening diarrhea with Metamucil.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE Research in the Service of Medicine

A Score Settled...

Sgt. Ronald E. Rosser, U.S. Army
Medal of Honor



WHEN HIS BROTHER was killed in Korea, Sergeant Rosser re-enlisted. Several months later he, too, was in Korea—pinned down on a hill near Pongil-li by surprise Red fire. He saw it cutting up the platoon. Suddenly he jumped to his feet, charged a Red bunker and cleaned it out. In a trench he dispatched five more enemies. Twice, under heavy fire, he returned for more ammunition, then renewed his attack. His furious one-man fight ended with 13 enemy dead, the American platoon saved, and a score settled for Sergeant Ronald Rosser.

"When a man gets back from Korea," says Sergeant Rosser, "it does him good to see people investing in our country's Bonds. Sure, Bonds are a practical way to save, I know. But they also help build *production power*—to equip and protect men overseas. And that's proof that people really care."

Peace is for the strong! For peace and prosperity save with U.S. Defense Bonds!

Now E Bonds pay 3%! Now, improved Series E Bonds start paying interest after 6 months. And average 3% interest, compounded semiannually when held to maturity! Also, all *maturing* E Bonds automatically *go on* earning—at the new rate—for 10 *more* years. Today, start investing in U.S. Series E Defense Bonds through the Payroll Savings Plan.

The U. S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

535 North Dearborn Street, Chicago 10, Illinois

AN MEDICAL ASSOCIATION news notes

MAY 1953

AMA news written especially for use in state medical journals

AMA Meeting to Be Aired on Radio and TV

Physicians who cannot attend the AMA's 102nd annual convention can see and hear highlights of the meeting via radio and television.

The presidential inaugural ceremony will be broadcast coast to coast on Wednesday, June 3. Although the inauguration of President-Elect Edward J. McCormick will be held Tuesday, the coronation of Queen Elizabeth II of England on the same day —which will be widely covered by radio and television—has made it necessary to re-broadcast the proceedings on Wednesday evening.

In television areas, the half-hour "March of Medicine" program, originating at the Scientific Exhibit in New York's Grand Central Palace, will be presented either Thursday or Friday evening. This television coverage will be sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

Futher information on these two programs will be available in the near future.

European MD Contributes to AMEF

A European-educated physician now residing in Madera, California, believes that physicians should support American medical schools. Although he owes no allegiance to any school in this country, Dr. Thomas Klein sent in a donation to the American Medical Education Foundation. His action sets an example for graduates of American medical colleges. In less than three months of this year, the Foundation has received in excess of $657,000 from more than 7,000 contributors towards its 1953 goal of $2,000,000.

There's News in Rural Health Meeting

Reporters were quick to spot news in a gathering of more than 600 persons at AMA's eighth national Conference on Rural Health, held Feb. 27–28 in Roanoke, Virginia. The meeting—the largest yet—drew representatives from medical and agricultural groups in 42 states and the District of Columbia.

To publicize the Conference, AMA sent packets containing 10 different releases to more than 500 newspapers, radio stations, wire services, and farm publications throughout the country. Reporters assigned by Roanoke's two papers filled several columns each day with stories, photos, and interviews.

Radio–TV coverage was excellent. Roanoke's three stations carried 12 interview programs plus extensive commentary on news shows. Sixty-two Virginia stations each received five tape-recorded programs on rural health as a service of Virginia Polytechnic Institute, whose radio director taped them at the Conference. It can be estimated that more than 500 radio programs mentioning the Rural Health Conference were presented throughout the United States.

Factbook on Medical Education

Current statistics on medical education in the United States have been compiled in a convenient pocket-sized booklet for handy reference distributed early in April by the American Medical Association. Information contained in the "Factbook on Medical Education" is based on a report made by the Council on Medical Education and Hospitals during the academic year 1951–52. Written in an easy question-and-answer style, the new booklet gives information on enrollments, financial support, faculty, and new medical schools. The booklet was distributed to state and county medical society officers, AMA delegates and officers, newspaper and magazine writers, and allied health organizations. Additional copies are available for distribution by state and county medical societies.

AMA Exhibits Face Big Year

To all four corners of the country go AMA exhibits! These exhibits are displayed not only at AMA annual and clinical meetings but also at home and food shows, automobile shows, farm shows, state and county fairs, and over television. So far in 1953 there have been 130 exhibition days in 7 states. Bookings now on hand total 187 days of exhibit showings in 21 states, with a total of 43 different showings already scheduled.

So popular has been the display entitled "Testing the Drinking Driver" that two copies were prepared. Last year one of these was shown 96 days before 19 different groups in 9 states, while the other copy was shown 84 days before 22 groups in 11 states. All bookings are handled through the Bureau of Exhibits.

Films Cleared for TV

Three films produced by the Metropolitan Life Insurance Company recently were cleared for use on educational and public service television programs. "Once Upon a Time," a 10-minute animated cartoon dealing with state and highway safety; "Proof of the Pudding," a 10-minute dramatic presentation showing the essentials of good nutrition and the relation between diet and health; "Be Your Age," an 11½-minute drama depicting middle-aged, over-weight "John's" recovery from a heart attack and his subsequent adjustment to living with a handicapped heart. The films are available to county medical societies who desire to co-sponsor these films on television. They may be secured from Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, N.Y.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Epileptics in Wisconsin

"The Wisconsin State Medical Society is backing a proposal to change the status of the epileptic in the Wisconsin marriage law. At present the epileptic is denied a marriage license and classed along with the imbecile and the insane.

"From all the evidence gathered, it is high time that the law is changed. But not only the legal transference or the medical authority for the status of the epileptic is necessary. Public opinion has to undergo some education on the subject too.

"The cause of most epilepsy is still unknown. There are cases of a 'traumatic' nature caused by brain injury at birth or in a later accident. The others appear to be similar to an electrical brain storm that temporarily makes the sufferer unconscious . . . But apparently there are no evil after-effects. The so-called 'epileptic personality' is now thought to be the result of discrimination and not caused by the disease itself."—APPLETON POST-CRESCENT, April 13, 1953.

"There is still some difference of opinion in the medical profession about the inheritance of epilepsy. Apparently an epileptic parent has one chance in forty to have an epileptic child. The percentage among the public is one in two hundred. But the tendency to such diseases as coronary trouble, diabetes, tuberculosis and cancer also appears to be inherited. Marriage laws restrict such applicants in no way.

. . . "The change in the marriage law is a big step toward acceptance. And the doctors, who should know, are firmly behind it."—GREEN BAY PRESS-GAZETTE, April 13, 1953.

Backing Polio Into the Corner

"Dr. Jonas E. Salk, the medical scientist who has developed a vaccine destructive of polio, was induced to discuss the matter prematurely because rumor was flaming to the skies about it and it was thought advisable to give the exact facts with an impressive caution. He therefore disclosed that the experimental inoculation of 90 youngsters with his multiple type vaccine, directed against all three types of polio, produced a highly optimistic result.

"He combined the statement of facts with an emphatic warning to the public not to jump to conclusions, because he is not yet prepared to say what will be developed by still necessary research and that to hazard guesses at the first good signs is not an intelligent way to handle a vicious foe.

"When such cautions come from recognized authorities they cannot, however wise, stay the growing belief that polio has been backed into its last corner where it will be pounded into a pulp and stretched out along with such other exhibits as diphtheria, now no longer even a mild terror to those who will use a little precaution."—APPLETON POST-CRESCENT, April 6, 1953.

"More Medical Miracles"

"New noses, chins and other facial sections and parts for human beings are being built these days by plastic surgeons using cartilage taken from young cattle.

"A soft, white, rubbery substance located at the end of the steer's breast-bone has been transplanted successfully in scores of recent operations, reports Capper's Farmer. The cartilage is removed immediately after an animal has been slaughtered, and is then processed and stored in a sterile solution for future use.

"While it isn't in the same class, medically speaking, let's not forget that there's still a lot of beefsteak used for black eyes!"—BELOIT NEWS, March 12, 1953.

Increase in Mental Patients

"In 1941 there were 15,182 persons in the public mental institutions of Wisconsin, state and county. Ten years later the number had increased to 17,161, according to a recent report of the state department of public welfare. . .

"This is not an alarming increase. In the first place, the state's population increased by almost 10 per cent in the same period, so the number of persons institutionalized for mental difficulties increased only from 484 to 500 per 10,000 of population. This increase may be wholly attributable to the present longer life span and to greater willingness to accept treatment.

"Our problem today is to prevent the occurrence of mental trouble wherever possible, to detect the trouble while it is still easily curable, to provide more intensive treatment so that the period of hospitalization (and economic dependence) may be shortened and, finally, to find better methods of both prevention and cure."—MILWAUKEE JOURNAL, April 9, 1953.

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KINNEY-MANSFIELD DIVISION

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

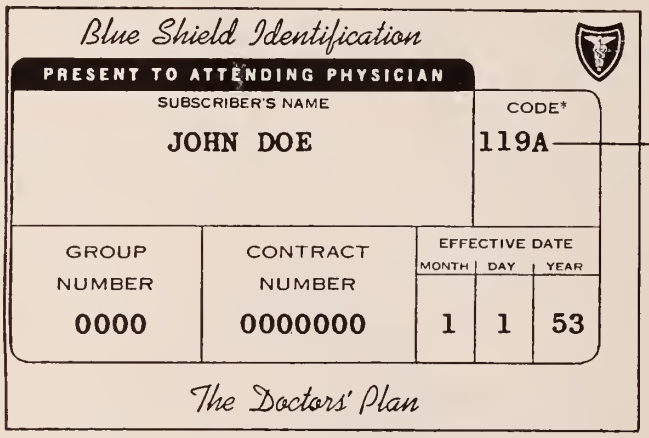
The Patient's Identification Card

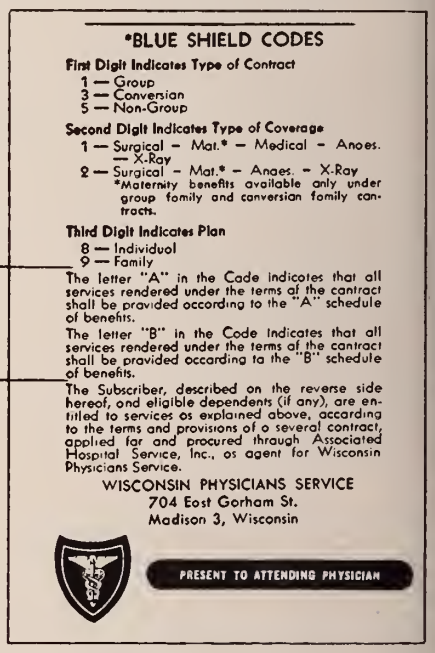
Every Blue Shield subscriber is given an Identification Card of the type shown below. All subscribers are informed that they must present this Identification Card to the physician each time services are requested for themselves or their dependents.

Obviously, however, the mere possession of an Identification Card is not positive proof of coverage under Blue Shield. One of the common causes of rejection of Blue Shield claims is that the person for whom services were rendered did not actually have coverage in force at the time services were performed.

The Blue Shield Identification Card is issued only to the subscriber. When care is rendered to dependents of the subscriber you should ask them to obtain the card and show it to you or your secretary.

The Identification Card is particularly helpful when you are reporting surgical services rendered in your office. For purposes of reporting such services you or your secretary can copy the group number, the contract number, and name of subscriber from the Identification Card and type them in the proper places on the Physicians Service Report. At the same time, be sure to obtain the name of the patient, relationship of the patient to subscriber, and address of the subscriber.





Persons who present Identification Cards are eligible for Blue Shield benefits *only* if their premiums are currently paid.

Probably the most important information that the physician may obtain from the Identification Card when it is presented to the doctor or his office employees is whether the person is covered under the "A" or "B" schedule of benefits.

The letter "A" in the code box indicates that the "A" schedule of benefits will be provided for services rendered to the covered persons.

The letter "B" in the code box indicates that the "B" schedule of benefits will be provided for services rendered to the covered persons.

Patients who are covered by Blue Shield expect the plan to help them prepay the costs of care resulting from illness or injury. Asking the patient to show his Blue Shield Identification Card should cause no more embarrassment than that occasioned by the department store clerk who requests a charge plate when you wish to purchase something on account.

"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26. 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

COMMITTEE *Concentrates*

COMMISSION ON PREPAID PLANS

MARCH 28–29

MDs present: E. M. Dessloch (chairman), Robert Krohn, N. A. Hill, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, W. C. Stewart, H. B. Christianson, G. W. Carlson, W. T. Casper, J. T. Sprague, Richard Foregger, R. C. Parkin.

Claims, Enrollment and Underwriting, Physician and Public Relations, and Research and Development Committees met Saturday before the Commission meeting . . . Multiple thoracenteses paid individually, no reduced fee after first of a series . . . Fees established for enterocele, $100 "A" schedule, $75 "B" schedule . . . Treatment of poison ivy not a surgical procedure . . . Waiting periods in contract must be applied strictly, unusual cases considered by Claims Committee . . . Subscribers in groups falling below minimum size may continue to be billed, at conversion rate, through the group . . . Adopted a policy on overlapping group coverage outlining procedures for new and existing situations . . . Approved 1953 WPS budget based on claim volume . . . Clinic managers may sign physicians' claims as agent . . . Approved an advertising budget for balance of year . . . Secretaries' conferences to be continued annually . . . Approved first draft of a Physicians Manual . . . Gave go-ahead to conducting a community enrollment program . . . Approved a plan for indemnifying subscribers over the "A" income limits in multiples of 25 per cent of the "A" schedule to a maximum of "A" plus 100 per cent . . . Irradiated iodine, gold, cobalt, and other radioactive elements not classified as medical or surgical under present contract; receive a benefit equal to in-hospital medical benefits for the present . . . Directed the early development of an indemnity policy in the field of catastrophic insurance . . . In-hospital medical care may be increased up to 120 days, at adjusted rate, with retention of full payment provision . . . Surgical benefits for newborn from first day of life soon to be available.

SUB-COMMITTEE ON COMMITMENT LAWS OF THE DIVISION ON MENTAL AND NERVOUS DISEASES

APRIL 7

MDs present: Keith Keane (chairman), Walter Urben, J. T. Petersik, Owen Clark, J. F. Klepfer, R. A. Jefferson, Michael Kasak, E. D. Schwade.

As this was the first meeting of this committee most discussion centered around basic problems in respect to present laws, and study of model law proposed by FSA. Agreed to notify county judges, bar association, and Department of Public Welfare as to project, to secure coordination with these groups as the study is developed. Next meeting to be held on June 2, at which time model laws of Utah and Illinois will be discussed.

COMMISSION ON STATE DEPARTMENTS

APRIL 8

MDs present: T. W. Tormey, Jr. (chairman), T. L. Tolan, J. A. Schindler, H. W. Carey, P. J. Collopy (substituting for R. G. Piaskoski).

Reports of several divisions presented, with specific recommendations. Favorable action on appointment of A. A. Lorenz, M. D., Eau Claire, as member of Division on Mental and Nervous Diseases; Robert O'Connor, M. D., Madison, to sub-committee on Emotionally Disturbed Child of the Division on Mental and Nervous Diseases; appointment of E. A. Birge, M. D., Milwaukee, as member of Division on Maternal and Child Health; appointment of Drs. Owen Clark and J. F. Klepfer, as members of a special sub-committee of Division on Mental and Nervous Diseases to study the commitment laws; approved resolution of Division on Mental and Nervous Diseases concerning consideration for military deferment of key personnel in mental institutions; approved plan on visual screening program submitted by Division on Hearing and Visual Defects; approved conditional report on rheumatic fever program submitted by Division on Crippled Children. Representatives of various state departments outlined current problems which might be considered by the several divisions of the Commission. Chairmen of Divisions on Rehabilitation, Public Assistance, and Geriatrics urged to schedule early meetings. Approved suggestion of setting up special Committee on Venereal Diseases, which would report to the Commission. Garrett Cooper, M. D., Madison, named as chairman and authorized to select committee on advice of State Health Officer. Meeting to be held in early September to consider further reports of Divisions.

(Continued on Page 32)

A Marked Advance in Oral Estrogen therapy

no odor or after-odor

no taste or after taste

HAVE you tested the new degrees of effectiveness and acceptability provided by SULESTREX?

Results are prompt, constant, and predictable . . . "*with an amazingly low incidence of side reactions.*"[1] Regardless of the intensity of treatment, there is no possibility of esthetic "embarrassment."

Measure these advantages when prescribing for your next menopausal patient. SULESTREX (piperazine estrone sulfate, Abbott) provides the natural estrogen, estrone, in pure crystalline form. It is not a mixture of estrogenic agents of variable potencies. SULESTREX is stable, water-soluble, odorless and tasteless.

You may choose from three prescribing forms: Tablets,* Sub-U-Tabs,** and Elixir.* Try it soon, with this confidence: you can't prescribe a more effective oral estrogen.

Abbott

Sulestrex®

Piperazine

* AMA Council Accepted
** T.M. for Sublingual Tablets, Abbott
1. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

1-16[illegible]

SUB-COMMITTEE ON EMOTIONALLY DISTURBED CHILD OF THE DIVISION ON MENTAL AND NERVOUS DISEASES

APRIL 12

MDs present: M. G. Peterman (chairman), Sara Geiger, Owen Otto, John Gonce, Robert O'Connor, A. A. Lorenz, E. D. Schwade, and Leslie Osborn.

Primary purpose of meeting to secure better understanding of related work of Division on Children and Youth of Department of Public Welfare. Director Fred DelliQuadri and assistant, Dorothy Waite, in attendance. Review of past inability to provide special facilities in Milwaukee County, and discussion of how the current situation and attitude of the County Board could be determined, with thought in mind of having improved facilities provided. Discussed with Doctor Osborn the policies of the Diagnostic Center concerning evaluation of problems related to emotionally disturbed children. Recommended that series of professional education meetings be set up next year, to interpret special problems of medical significance in reference to the emotionally disturbed and mentally retarded child. At later date committee will meet with director of public assistance and also executive secretary of Wisconsin Association for Mental Health.

COMMITTEE ON MILITARY MEDICAL SERVICE

APRIL 16

MDs present: F. L. Weston (chairman), O. G. Moland, J. M. Sullivan.

Individual consideration was given to a number of cases to determine essentiality and availability of physicians. The committee was informed that calls for physicians in Priority III born before August 31, 1922, had been cancelled. However, it is apparent that the military does not believe that the supply of interns and residents that will become available in June will be sufficient to fulfill all needs for more than four or five months. Thus, it appears that Priority III physicians in the older age brackets may again be called by late fall.

MATERNAL MORTALITY STUDY COMMITTEE

APRIL 18

MDs present: T. A. Leonard (chairman), J. W. Harris, F. J. Hofmeister, Alice Watts, R. J. Sanderson, E. D. Wilkinson.

First meeting of this committee, to review reports of cases related to maternal deaths. Discussion of each case and preparation of summary made a responsibility of the chairman, with final report subject to review before being sent to attending physician and chief of staff of hospital where death occurred. Also set up procedures where certain deaths of pregnant women, related to accidents or other factors not associated with pregnancy, might be evaluated by special letter sent direct to attending physicians. Dr. William Luetke, Madison, asked to assume this responsibility for the Study Committee. Next meeting will be scheduled as new supply of case reports is ready for review.

COMMITTEE ON CANCER

APRIL 25

MDs present: W. S. Bump, A. C. Taylor, R. P. Welbourne, J. W. Conklin, R. B. Larson.

Meeting primarily as Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society, voted to use funds of the Wisconsin Division for pathologists or technicians of approved laboratories to take special work in cytologic examinations at State Laboratory under supervision of Doctor Stovall and his staff . . . Approved application for special research grant to U. of W. Medical School and McArdle for $7,000 to cover project related to cause of bladder cancer . . . Approved development of series of professional education meetings on cancer last week of October, to be held in Eau Claire, Wausau, and Appleton or Neenah to cover these subjects: cytologic examinations, lung cancer, uterine cancer, and oral cancer (all dentists as well as MDs in the area will be invited to attend this last meeting; feel this to be good inter-professional relations) . . . Approved using funds of Wisconsin Division to underwrite speaker on cancer at 1954 meeting of State Dental Society . . . Approved issuance of leaflet on biopsy and smears, to be used by MDs in contact with patients.

RELATED ACTIVITIES

Representatives of Blood Bank Committee have held two meetings with State Board of Health staff to iron out details of program in respect to distribution of gamma globulin. Special letters to all MDs and newspaper editors sent out first part of May to "get program off on right foot" . . . Initial evaluations of Maternal Mortality Study Committee indicate need to emphasize to prospective mothers value of prenatal care. Several deaths studied to date among women with previous pregnancies show lack of public understanding on importance of close medical supervision before delivery . . . Notes on professional education: Clinics in West Bend, Shawano, and Stevens Point were excellent teaching programs but had small attendance. General programs in 1953 reflect fact that "too many medical meetings" is common complaint of busy MD, which is reflected in just fair response to excellent teaching programs offered. Increasing interest in medical developments in cancer research has prompted the Committee on Cancer (as the Medical and Scientific Committee of the Wisconsin Division of American Cancer Society) to recommend series of cancer meetings for MDs and dentists late next October. Subjects to be discussed: lung cancer, uterine cancer, cytologic examinations, and oral cancer. Sites to be Eau Claire, Wausau, and either Appleton or Neenah . . . Series of medical meetings related to Hearing Loss in Industry to be sponsored jointly by Committee on Industrial Health of SMS, State Board of Health, Wisconsin Council of Safety, and Wisconsin Manufacturers Association next fall. Sites and dates: Sept. 10, Wausau; Sept. 24, Oshkosh; Oct. 14, Racine. All MDs in any way associated with plant programs will find these meetings a "must," as MDs will be expected to set up testing and evaluation programs for employees.

Cancer strikes 1 in 5

Strike back

Give

Your gifts to the American Cancer Society help guard those you love.

Your dollars support research in a hundred laboratories and universities . . . spread life-saving information . . . ease pain and suffering . . . provide facilities for treatment and care of cancer patients.

It is a sobering fact that cancer may strike anyone tomorrow: strike back today with a gift to the American Cancer Society. You may mail it, simply addressed CANCER, c/o your local post office.

American Cancer Society

Society Proceedings

Ashland–Bayfield–Iron

Dr. Sam Boyer, Jr., Duluth, Minn., was the speaker for the scientific portion of the March 25 meeting of the Ashland–Bayfield–Iron County Medical Society, held at the Menard Hotel in Ashland.

The annual election of officers was held and *Dr. W. J. Tucker*, Ashland, is the new president. Other physicians serving with him are *L. W. Moody*, Bayfield, vice-president; *J. M. Jauquet*, Ashland, secretary; *J. W. Prentice*, Ashland, delegate; and Doctor Jauquet, alternate. There was also a discussion on a proposal by the State Society that it prepare tape recordings on various scientific subjects for use by county societies and hospital staffs. The members approved the plan.

Brown–Kewaunee–Door

The April meeting of the Brown–Kewaunee–Door County Medical Society was held at the Elks Club in Green Bay on Thursday, April 9. Guest speaker for the scientific portion of the program was *Dr. Douglas A. Gutheil*, medical director of Hickory Grove Sanatorium, West DePere. He chose "Current Tuberculosis Therapy" as the title of his talk.

The other speaker was Mr. Frank Cartier of the Industrial Committee of the Association of Commerce of Green Bay, who discussed "Industrial Progress in Green Bay."

Calumet

A dinner meeting of the Calumet County Medical Society was held on February 26 at Otto's Steak House in Hilbert. During the business session, plans were discussed for the meeting of the Fifth Councilor District which will be held in New Holstein on June 25. Approximately 200 people are expected to attend the meeting.

Grant

Dr. Henry M. Suckle of Madison was guest speaker at the December 1952 meeting of the Grant County Medical Society. Meeting with members of the society at the Boscobel Hotel, the doctor presented a paper on "Head Injuries." The annual election of officers was held and resulted in the following slate to serve in 1953:

President—*J. L. Moffett*, Platteville
Vice-President—*E. M. Randall*, Boscobel
Secretary–Treasurer—*H. W. Carey*, Lancaster
Delegate—*J. W. Conklin*, Platteville
Alternate—*K. L. Bauman*, Lancaster

Kenosha

"Medical Problems" was the title of an address by *Dr. J. C. Griffith* of Milwaukee at the April 2 meeting of the Kenosha County Medical Society, held in Kenosha at the Elks Club. Doctor Griffith is president of the State Society.

During the business portion of the meeting, members discussed Chiropractic Bill 330, A., a revision of the emergency call service, and the annual examination of Girl Scouts.

Marinette–Florence

St. Joseph's–Lloyd Hospital in Menominee, Mich., was the site of the April 15 meeting of the Marinette–Florence County Medical Society. The guest speaker for this occasion was *Dr. R. P. Gingrass* of Milwaukee, who talked on "Dental Surgery."

Pierce–St. Croix

On March 31 the members of the Pierce–St. Croix County Medical Society held their regular monthly meeting at the Terrace in Somerset. The society met at the Hotel Dibbo in Hudson for its April 21 program. *Dr. C. F. McCusker* of Glenwood City was host for the Hudson meeting.

Richland

The Richland County Medical Society sponsored an otologic clinic on March 16 in Richland Center. Conducted by the Bureau for Handicapped Children, the clinic examined a total of 45 children in the county who had been found to have possible hearing difficulties.

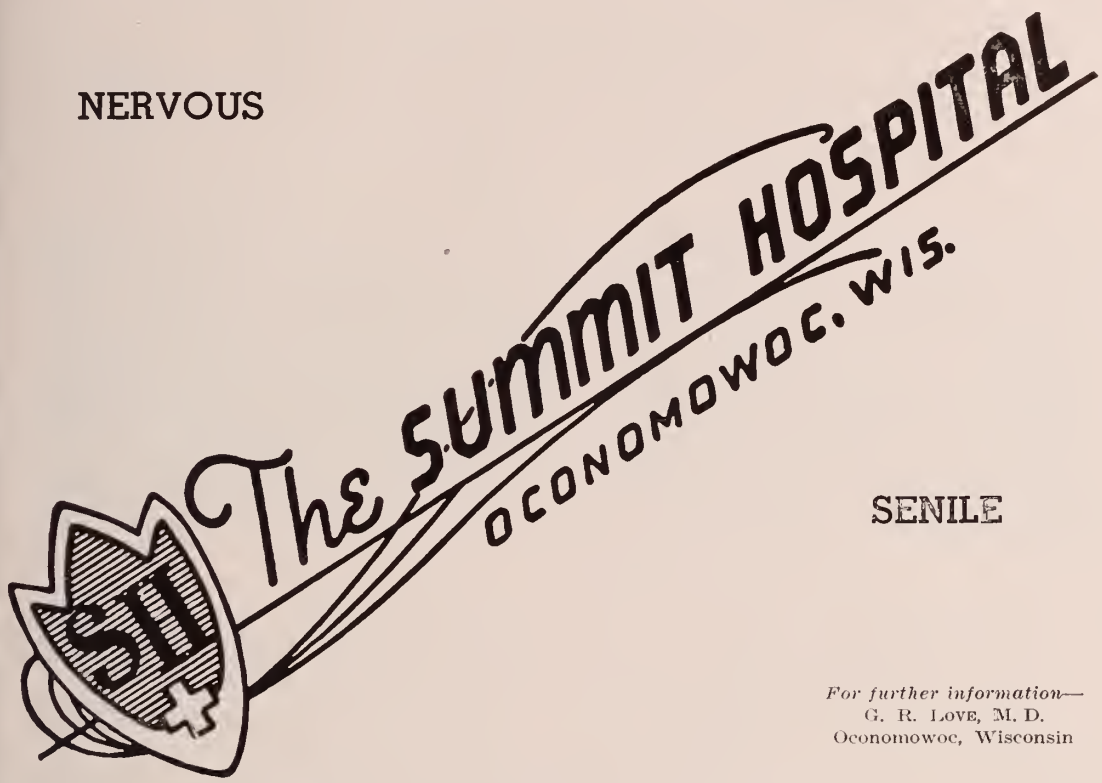
Shawano

The Shawano County Medical Society and the medical staff of the Shawano Municipal Hospital held their regular monthly dinner meeting on March 18. A representative of the hospital auxiliary discussed the many functions of the auxiliary in helping the hospital to serve the community and county. The society and staff expressed unanimous approval of the work the organization had done in the past.

Trempealeau–Jackson–Buffalo

On March 10, Mr. Jack Foster of the Linde Air Products Company addressed the Trempealeau-Jackson–Buffalo County Medical Society. Meeting with members of the society at the Club Midway in Independence, Mr. Foster discussed "Oxygen Therapy."

NERVOUS



SENILE

For further information—
G. R. LOVE, M. D.
Oconomowoc, Wisconsin

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

Prescribe Journal-advertised products and you prescribe the best.

Walworth

Officers for 1953 were chosen by the Walworth County Medical Society at a meeting held in January. The physicians honored are *Laird McNeel*, Genoa City, president; *R. A. Moses*, Delavan, vice-president; *G. O. Truex*, Darien, secretary-treasurer; *E. D. Sorenson*, Elkhorn, delegate; and *E. D. Hudson*, Lake Geneva, alternate.

Winnebago

The regular meeting of the Winnebago County Medical Society was held on Thursday, April 9, at the Athearn Hotel, Oshkosh. Speaker of the evening was *Dr. Edward A. Bachhuber* of Milwaukee, who chose as his subject, "Bowel Obstruction."

Doctor Bachhuber is assistant dean of Marquette University School of Medicine.

News Items and Personals

Campbells Attend World Medical Conference

Wisconsin's guests of honor at the First Western Hemisphere Conference of the World Medical Association, held in Richmond, Va., from April 23 to 25 in observance of the lengthening of life and the constant improvement of human health, were *Dr. W. B. Campbell* and Mrs. Campbell of Waukesha. Along with 47 other physicians who are 75 this year, Doctor Campbell was invited to attend the conference and tell of medical advances that have taken place during his lifetime. As the six most important advances he has witnessed, Doctor Campbell named new chemotherapeutic drugs, blood and plasma transfusions, discovery and development of x-rays, better care of premature infants, new surgical procedures, and new immunization technics.

Born in 1878, Doctor Campbell is engaged in industrial practice in Waukesha. He is an 1899 graduate of the University of Illinois College of Medicine.

Guests at the conference were greeted by Dr. Louis H. Bauer, president of the American Medical Association, and by leaders of Latin–American medical societies. Besides attending scientific sessions, guests had an opportunity to visit historic sites in Virginia, including the 18th century Williamsburg restoration. Conference costs were covered through a grant by the A. H. Robins Co., Inc., a pharmaceutical house founded in Richmond 75 years ago this year.

DR. W. B. CAMPBELL

Dr. Reed M. Simpson Takes Coroner's Job

Dr. Reed M. Simpson of Sheboygan has been appointed Sheboygan County coroner to serve the remainder of the unexpired term of *Dr. James F. Hildebrand*, Sheboygan, who has resigned the post to return to military service.

A practicing physician and surgeon in Sheboygan since his discharge from the Army Medical Corps in 1946, Doctor Simpson is a graduate of the Washington University School of Medicine in St. Louis and served his internship at DePaul Hospital there before establishing a practice at Medora, Ill., in 1939. He is a native of Pittsburgh, Pa.

Doctor Hildebrand, who began his third term as coroner in January, reported on March 19 for a two year tour of duty with the 3700th Medical Group at Lackland Air Force Base, San Antonio, Texas.

Doctor Hatleberg Given Surprise Party

A surprise party, complete with songs, a gift, and original poetry, was given by the surgical staff of St. Joseph's Hospital in Chippewa Falls in honor of *Dr. C. B. Hatleberg*, who is observing his 30th anniversary as surgeon at the hospital. Held late in February, the party was arranged by the sisters and nurses in the surgical department.

Dr. Alvin Thieler Addresses Cancer Society

In a talk before volunteer workers of the Green Lake County Cancer Society on February 17 *Dr. Alvin C. Thieler* of Princeton stressed the importance of the work of the society in educating the layman about cancer. "We doctors want to get people to report symptoms of cancer to us as soon as they appear," he said, "so that the disease can be checked in its early stages." The doctor added that the unnecessary fear that normally accompanies such symptoms has to be overcome.

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

SINCE 1913

Complete Laboratories Serving Wisconsin:
Beloit, Wis. Eau Claire, Wis. Superior, Wis.
Duluth, Minn. La Crosse, Wis. Wausau, Wis.
Stevens Point, Wis.

Benson
OPTICAL COMPANY

EXECUTIVE OFFICES • MINNEAPOLIS, MINN.

Prescribe Journal-advertised products and you prescribe the best.

LIBRARY OF THE
COLLEGE OF PH

Your Visit to Milwaukee

Is Made More Enjoyable by
Stopping at the SCHROEDER

Metropolitan atmosphere
Cocktail Lounge
Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Vatican Honors Dr. J. M. Albino

J. M. ALBINO

In recognition of his "humanitarian and welfare work" for the Italian people and those of Italian extraction, *Dr. J. M. Albino* of Racine received a citation and gold medal of the Chancellor of the Order of the Lateran Cross at a banquet February 28 sponsored by the Italian – American Brotherhood and the OFDI Roma Lodge in Racine.

Issued in ancient times to Lateran knights for outstanding service, the Order of the Lateran Cross was extended by the Vatican in 1903 to include individuals who had rendered service to humanity in civic, cultural, military, or religious fields.

In 1951 Doctor Albino was decorated by the Italian government for his post-war medical aid to Italy. Last year he served as president of the Racine County Medical Society.

Two Doctors Buy Old Darlington Hospital

Word has been received of the sale of the old hospital in Darlington to *Drs. Lyle L. Olson* and *Robert E. Oertley* of Monroe, who plan to form a partnership in the general practice of medicine in Darlington. Now residents at St. Clare Hospital in Monroe, the two doctors will take possession of the building on June 1 and move to Darlington on July 1.

Dr. J. A. Schindler Discusses Emotions

The "wrong kind of emotions" can cause physical illness, *Dr. John A. Schindler* of Monroe told a group of Portage teachers and their wives at the annual spring dinner meeting of the Portage Teachers Association on February 26. In discussing the common attitude toward any illness that springs from emotional rather than physical causes, Doctor Schindler said that "emotional disease isn't often diagnosed, because it would take about a minimum of 20 hours for treatment." As a substitute for proper treatment many people, Doctor Schindler feels, employ methods which simply prolong the duration of the disease.

To develop healthy emotions Doctor Schindler advised the teachers to learn how to say "Nuts!" to an unpleasant situation and take it in their stride.

Colby Gains, Loses a Doctor

After more than a year of practicing in both Owen and Colby, *Dr. J. W. Koch* has closed his Owen office and set up permanent practice in Colby. The change was completed on March 9.

A few days earlier, on March 5, *Dr. Frank F. Nelson*, a classmate of Doctor Koch's at the Univer-

sity of Wisconsin Medical School, left his post as head of the Colby Clinic to accept a three year residency in radiology at St. Vincent's Hospital in New York City.

Both men graduated from the University of Wisconsin Medical School in 1950. Doctor Koch, a native of Butternut, interned at St. Joseph's Hospital in Marshfield before beginning practice. Doctor Nelson, who was born in Kenosha, served his internship at St. Francis Hospital in La Crosse and joined the Colby Clinic on Aug. 1, 1951.

Platteville Doctor Cited for Long Service

A recent issue of *The Crusader*, monthly journal of the Wisconsin Anti-Tuberculosis Association, cites *Dr. Wilson Cunningham* of Platteville for his long service in leading the way to improved medical service in his community, including a program for routine chest x-rays for all incoming patients. At 81, Doctor Cunningham is chief of staff of the Platteville Municipal Hospital and operates the Cunningham Clinic with *Drs. J. W. Conklin* and *H. L. Doeringsfeld.*

When Doctor Cunningham came to Platteville in 1900, his idea was to stay for three years and then return to Chicago to set up permanent practice. Five years later he decided to stay in Platteville, where he has remained ever since.

Doctor Cunningham is responsible for giving the Platteville area its first and, until the opening of the new municipal hospital in October 1950, only hospital. He is the author of several widely used inventions, including animal bone splints and screws for fractures and bone spheres used in case of eye loss.

An active member of the State Medical Society since he came to Platteville, Doctor Cunningham served on its Council for 30 years and in 1925 was its president. He has also been active in the Wisconsin Anti-Tuberculosis Association and the Wisconsin division of the American Cancer Society and has given many lectures on cancer and tuberculosis.

Nurses' Group Hears Dr. John Russo

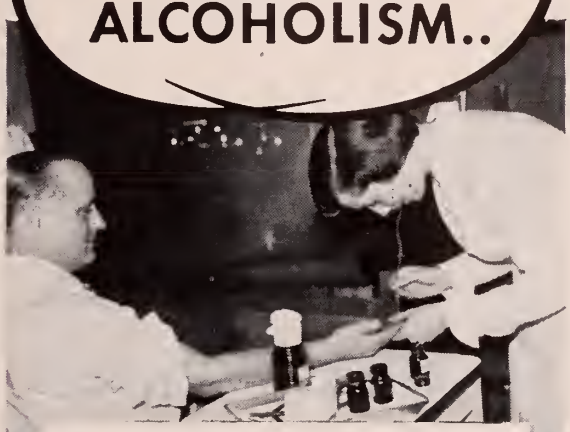
A discussion by *Dr. John G. Russo* on modern treatments of tuberculosis and foreign bodies in the air and food passages was the feature of a general meeting of Appleton district members of the Wisconsin Nurses Association March 4 at Riverview Sanatorium. Doctor Russo is superintendent of the Sanatorium.

Doctors Speak to Parent–Teacher Groups

Dr. John A. Van Susteren, District 4 health officer of the State Board of Health, was principal speaker at a meeting of the four PTA's of Sparta's public school system on March 10. To accompany his speech, Doctor Van Susteren showed a movie on health.

At the March 12 meeting of the Glidden High School PTA, *Dr. L. W. Moody* was the main speaker

When You Refer Patients with ALCOHOLISM..



Blood examinations, urinalysis, liver function, B.M.R., blood sugar and other important diagnostic tests are performed in a modern, well-equipped laboratory.

Years of experience in the specialized care of alcoholic addiction enable The Keeley Institute to embody the following phases of therapeutic approach—gradual withdrawal, physical rehabilitation, re-orientation and re-education.

Soon after admission the patient is given a thorough physical examination and laboratory studies. His nutritional status—highly important in alcoholism—is thoroughly investigated. Pertinent information regarding physical and psychosomatic disorders is obtained and related to each successive examination.

All patients receive the utmost consideration from our staff of full-time physicians. Restraining methods and avulsive reactors are not employed. The referring physician is constantly informed of the patient's progress.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

On Time

WHEN the "400" leaves Chicago on schedule, can they say in Minneapolis that it will arrive there on time? No, but if it arrives at all intervening points on time *they know* that it will arrive in Minneapolis on schedule.

Are you on time financially? Does your financial age parallel your physical age? The 45 year old man whose financial reserves correspond to those of a 30 year old man is 15 years behind schedule.

It is dangerous to count on making-up time. The surest financial plan yet devised to guarantee that you'll arrive at age 60 or 65 "in the money" is a Wisconsin Life Retirement Income Contract. As the years pass this plan helps you to keep on your schedule. It removes all guessing and chance. You know right where you stand. You arrive at retirement with cash to spend and enjoy leisurely living.

WISCONSIN LIFE INSURANCE CO.
30 W. MIFFLIN ST. MADISON, WIS.

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

of the evening. Doctor Moody is associated with the Pure Air Sanatorium.

Members of the Riverview PTA heard a speech by *Dr. John J. Suits* at their meeting on March 19. Doctor Suits is a pediatrician on the staff of the Marshfield Clinic.

Horicon, Hudson Woman's Clubs Hear Doctors

Psychosomatic illness was the topic of a speech by *Dr. J. H. Karsten* at a February meeting of the Junior Woman's Club of Horicon. He encouraged young mothers to maintain a good mental health balance.

At the regular meeting of the Hudson Junior Woman's Club on March 10 *Dr. George J. Hopkins* was the main speaker. Doctor Hopkins is associated with the Hudson Clinic.

Chicago Conference Draws Hartford Doctors

Attending the annual Spring Medical Conference at the Palmer House in Chicago from March 3 to 6 were *Drs. Earl O. Quackenbush, Maurice E. Monroe,* and *Theodore J. Kern* of Hartford. The conference was a postgraduate course sponsored by the Chicago Medical Society.

Dr. C. T. Droege Given Surprise Party

One Sunday in March *Dr. C. T. Droege,* Superior physician, and his family were invited for dinner at the home of their friends, Mr. and Mrs. George Karnas of State Line. Not a very remarkable event, on the face of it—but when the Karnases' neighbors began trouping into the house in groups of two's and three's, the unsuspecting doctor began to realize that this was no ordinary dinner invitation, but a carefully planned birthday party in his honor.

Movies of the party were taken from beginning to end, as Doctor Droege cut a birthday cake and opened his presents: a fishing box from the Karnases and tackle from each of the guests who were Doctor Droege's "babies."

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Allan Filek Leads Panel on Health

Control of illness and health examinations of school pupils and employees was the subject of a panel led by *Dr. Allan Filek,* director of the section on local health administration of the State Board of Health, at the Marshfield Senior High School on February 26. The panel was part of the professional in-service program in health guidance sponsored by the School Health Committee of the Marshfield Public Schools.

Doctor Filek, a graduate of Rush Medical College, has been associated with the State Board of Health since 1936.

Doctor Stovall Addresses WATA in Superior

Dr. William D. Stovall, director of the State Laboratory of Hygiene in Madison, was principal speaker at the annual dinner meeting of the Superior Chapter of the Wisconsin Anti-Tuberculosis Association on March 27 at the Hotel Superior. Assisting the association with this meeting was the Auxiliary to the Douglas County Medical Society.

Dr. T. C. Erickson Becomes Full Professor

T. C. ERICKSON

Word has been received of the promotion of *Dr. Theodore C. Erickson* from associate to full professor in the University of Wisconsin Medical School. His promotion was approved by the University Regents on February 4.

A specialist in the fields of neurophysiology, epilepsy, and hypertension, Doctor Erickson came to the University in 1941 as associate professor of neurosurgery. He received his training at the University of Minnesota, the University of Pennsylvania, McGill University, and the National Hospital in London, England.

Mendenhall to Serve at Medical School

Dr. John T. Mendenhall, chief of surgery at the Veterans Administration Hospital in Madison, has been appointed associate clinical professor of surgery in the University of Wisconsin Medical School. Doctor Mendenhall will serve without salary or tenure.

Dr. Albert J. Boner Conducts Forum

Dr. Albert J. Boner of Madison conducted a film forum at the organizational meeting of the Dane County Chapter of the Wisconsin Association for Mental Health on March 13 in Madison. "Fears of Children" and "It Takes All Kinds" were the films he chose for his presentation.

Doctor Beyer Joins Madison Group

Dr. J. A. Beyer, who was recently discharged from the Army Medical Corps, has become associated with *Drs. D. M. Britton, J. P. Malec, F. L. Hummer, W. A. Tanner,* and R. B. Anderson of Madison. He will specialize in internal medicine.

A native of Dover, N. J., Doctor Beyer received his medical degree from Columbia University College of Physicians and Surgeons and served his internship at the New York Postgraduate Hospital.

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

specialized service assures *"know-how"*

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 8-1021

KNOX GELATINE
AS A PHARMACEUTICAL PRODUCT

Not all gelatine is made with pharmaceutical care!

Not all gelatine is made like **KNOX**!

For example, **Knox** is made with the same rigid type of controls which are back of the only accepted blood plasma extender for use in shock management. A number of gelatines have an acid pH whereas the pH of **Knox Gelatine** is neutral.

For over 50 years **Knox** has always had the patient in mind, and every one of the seventeen steps in the **Knox** operation is controlled as carefully as the finest pharmaceutical, with the result that **Knox** standards are higher than U.S.P. and 85 to 87 per cent of **Knox Gelatine** is pure protein composed 100 per cent of various amino acids.

Knox Gelatine is practically standard in the diets of Diabetes, Colitis, Peptic Ulcer and Low Salt, Reducing and Liquid and Soft Diets.

If you are interested in seeing just how Knox Gelatine is made, write for our new photographic brochure, *"Behind the Scenes with Knox Gelatine"* (reading time—10 minutes). At the same time specify brochures on any diets mentioned above in which you may be interested. Knox Gelatine, Johnstown, N. Y. Dept. WS.

Available at grocery stores in 4-envelope family size and 32-envelope economy size packages.

KNOX GELATINE U. S. P.

ALL PROTEIN NO SUGAR

He taught for two years at Columbia as an instructor in pharmacology and also received a fellowship from the American Heart Association for study at the New York Hospital. Before coming to Madison, Doctor Beyer was stationed for two years at Percy Jones Army Hospital in Battle Creek, Mich., where he was chief of the cardiovascular section.

Doctor Tarrasch Addresses Delavan Mothers

Dr. Hertha Tarrasch, Janesville psychiatrist, addressed the mothers of the Delavan High School students on March 12. Doctor Tarrasch is psychiatrist for the Walworth County school system.

Sauk

The April 14 meeting of the Sauk County Medical Society was held at the Warren Hotel in Baraboo. *Dr. H. M. Suckle* of Madison, the featured speaker, discussed "Treatment of Head Injuries."

The Sherrington Society

"Tactile Thought, with Special Reference to the Blind" was the title of the third annual Sherrington Lecture, given February 20 in Madison by Dr. Macdonald Critchley, Dean of the Institute of Neurology of the National Hospital in London, England. The lecture was sponsored by the Sherrington Society of the University of Wisconsin.

Two Residents Receive Scholarship

Dr. John Huston, a resident at Milwaukee County General Hospital, and *Dr. Sherman P. Vinograd*, a resident at St. Mary's Hospital, Madison, attended the scientific sessions at the annual meeting of the American Heart Association in Atlantic City, N. J., April 8 to 12. The two men won scholarships from the Wisconsin Heart Association to attend the meeting.

Columbia Hospital Staff Elects Officers

Dr. John L. Garvey was re-elected chief of staff of Columbia Hospital by the executive committee of the hospital's board of directors at their April 2 meeting. All department chairmen were also re-elected. They are *Dr. Forrester Raine*, surgery; *Dr. Elwood W. Mason*, medicine; and *Dr. F. Jackson Stoddard*, obstetrics and gynecology.

Drs. A. Dwight Spooner, William F. Hovis, Jr., J. W. Thoma, and *George C. Owen* were elected members of the governing staff; and *Dr. Albert C. Schmidt* was named as delegate to the medical council, the executive committee of the medical staff.

Doctor Kasak Addresses Two Groups

The director of the Milwaukee County Hospital for Mental Disease, *Dr. Michael Kasak*, spoke before the annual meeting of the Manitoba School P.T.A. on March 10. The subject of his address was "Mental Health in Childhood."

On March 16 Doctor Kasak was guest speaker at a meeting of the Wisconsin Association of Medical Record Librarians held at the Hotel Schroeder. He discussed the shortage of psychiatrists in the United States.

Dr. A. A. Pleyte Addresses Parents

A. A. PLEYTE

Establishing regular hours for their children is one of the ways in which parents can guard them against rheumatic fever, *Dr. A. A. Pleyte* of Milwaukee told members of the Lincoln School PTA at their March 17 meeting in Cudahy. The doctor is a member of the board of directors of the Wisconsin Heart Association. Doctor Pleyte's talk and the film which followed emphasized the important way in which convalescent homes are restoring health to rheumatic fever patients.

Milwaukee

Dr. Alexander Brunschwig of New York City was the speaker sponsored by the Milwaukee division of the American Cancer Society for the April 9 meeting of the Medical Society of Milwaukee County. The doctor, who is attending surgeon at the Memorial Center for Cancer and Allied Diseases in New York City and professor of clinical surgery at Cornell University, told of results four and five years after treatment of cancer of the cervix by radical surgery.

Milwaukee Academy of Medicine

"Clinical Aspects of Ovarian Tumors" was the title of an address by Dr. W. F. Mengert, Dallas, Texas, at the April 21 meeting of the Milwaukee Academy of Medicine. Doctor Mengert is chairman of the department of obstetrics and gynecology at the Southwestern Medical School of the University of Texas.

Milwaukee Neuro-Psychiatric Society

Four scientific papers were presented at the April 15 meeting of the Milwaukee Neuro-Psychiatric Society. *Dr. Elizabeth D. Kane* of Green Bay spoke on "Differential Indications for the Use of Glutamic Acid"; Dr. Norman C. Mace, Wood, chose "The Response of Patients with Schizoid-Affective Reactions to Psychotherapy" as his subject; *Dr. Henry Veit*, Milwaukee, discussed "Treating the Alcoholic"; and *Dr. Chester M. Wade*, Milwaukee, closed the program with a talk entitled "Accident Prone—Safety Prone."

Medication Alone Does Not Solve **THE ALCOHOLIC PROBLEM**

AT IVANHOE—

a specially trained staff deals with the psychiatric, psychological and social aspects of the psychosomatic illnesses resulting in Alcohol Addiction.

Latest therapies and "know-how" have reduced the treatment period to an average of five days. Moderate fees.

Phone or write for information or reservation.

Alcohol patients only.

Restful Homelike Atmosphere
Near the Shores of Lake Michigan

IVANHOE SANITARIUM
of MILWAUKEE, WIS.

A REGISTERED HOSPITAL OF A.M.A.
Member American & Wisconsin Hosp. Assns.

2203 E. IVANHOE PLACE
Phone MArquette 8–4030

Accepted by the Medical Societies
Dedicated to the Medical Profession

SOCIETY RECORDS

New Members

C. R. Newman, 810 Main Street, Racine.

J. L. Jaeck, 1836 South Avenue, La Crosse.

J. P. McCann, 1836 South Avenue, La Crosse.

J. P. Pauly, 508 Batavian Bank Building, La Crosse.

J. R. Allen, 811 West Dayton Street, Madison.

D. H. Jeffers, Jr., 816 Wisconsin Street, Lake Geneva.

J. W. Harkness, 1411 Wauwatosa Avenue, Wauwatosa.

D. G. Ives, 1313 East Ann Street, Ann Arbor, Michigan.

H. L. Kuhl, Veterans Administration Center, Wood.

R. Parks LeTellier, 2200 West Kilbourn Street, Milwaukee.

E. K. Rath, 1133 South 15th Street, Milwaukee.

R. P. Reik, 2920 North 56th Street, Milwaukee.

L. G. Weed, 342 North Water Street, Milwaukee.

H. W. Bardenwerper, 225 East Main Street, Waterford.

W. O. Sydow, 4269 North 44th Place, Milwaukee.

P. B. O'Neill, 720 North Jefferson Street, Milwaukee.

D. W. Roberts, 3042 North Frederick Avenue, Milwaukee.

W. C. Harris, Veterans Administration Center, Wood.

Donald Ratke, 425 East Wisconsin Avenue, Milwaukee.

R. W. Cranston, 329 East Main Street, Platteville.

C. H. Shields, Jr., 1126 Lincoln Street, Fennimore.

V. E. McNeilus, Wild Rose.

L. L. Olson, Monroe Clinic, Monroe.

R. E. Oertley, 1020 18th Avenue, Monroe.

J. O. Hadley, 217 Main Street, Watertown.

W. H. Ruchie, St. Mary's Hospital, Racine.

F. C. Stiles, Monroe.

M. J. Olson, Monroe Clinic, Monroe.

Bernhard Kaufman, 161 West Wisconsin Avenue, Milwaukee.

Changes in Address

I. I. Kolman, Madison, to 606 West Wisconsin Avenue, Milwaukee.

E. F. Schubert, Logansport, Indiana, to Winnebago State Hospital, Winnebago.

Harry Horwich, New York, New York, to 20–45 Seagirt Avenue, Far Rockaway, Long Island, New York.

G. A. Mann, Menomonie, to 146 East Wentworth Avenue, West St. Paul, Minnesota.

J. K. Olinger,* Camp Cook, California, to Army Service Unit, U. S. Army Hospital, Fort Lawton, Washington.

J. S. Stehlin, Boston, Massachusetts, to 3474 North Downer Avenue, Milwaukee.

J. R. O'Connell, Milwaukee, to 7525 Portland Avenue, Wauwatosa.

H. V. Capparell, Wauwatosa, to West Psychiatric Institute, DeSoto and O'Hara Streets, Pittsburgh, Pennsylvania.

G. E. Fox,* Forest City, Iowa, to Veterans Hospital, Dearborn, Michigan.

W. F. Merdinger, Milwaukee, to Lahey Clinic, Boston, Massachusetts.

O. B. Rowlands,* Milwaukee, to Headquarters 2750th Medical Group, Army Medical Corps, Wright–Patterson Air Force Base, Dayton, Ohio.

T. J. Foley,* Milwaukee, to 136 Crouch Street, Oceanside, California.

J. Gurney Taylor, Miami, Florida, to 324 East Wisconsin Avenue, Milwaukee.

F. J. Pulito,* San Diego, California, to 3237 North Oakland Avenue, Milwaukee.

M. K. Schreiber,* Milwaukee, to 176 South Vista, Los Angeles, California.

Tukuso Taniguchi,* Seattle, Washington, to U. S. Army Hospital, Camp Pickett, Virginia.

C. R. Headlee, Milwaukee, to 9425 Beverly Place, Wauwatosa.

C. E. Hopkins,* Madison, to U.S.N.R., Camp Lejeune, North Carolina.

W. C. Randolph,* Manitowoc, to Chelsea Naval Hospital, Boston, Massachusetts.

R. A. Powell,* Kenosha, to Industrial Dispensary, U. S. Naval Air Sation, Pensacola, Florida.

J. W. Christofferson,* Shawano, to U. S. Naval Training Center, Great Lakes, Illinois.

Margaret E. Hatfield, Milwaukee, to District Health Office, Municipal Building, Elkhorn.

T. D. Foster,* Cornell, to U. S. S. Helena (CA–75), Fleet Post Office, San Francisco, California.

---

* Military Service.

DEATHS

Dr. George B. Noyes, Centuria physician, died February 26 at the age of 75. He had been in ill health for several years.

Born in Winneconne, Winnebago County, on June 20, 1887, Doctor Noyes was graduated from high school in Waupaca, where his father was surgeon at the Soldiers Home. On completing his training at Rush Medical College in Chicago in 1903, he served a year's internship at St. Mary's Hospital in Oshkosh. After several years of practice in Oshkosh, he moved to Stone Lake in 1911. In 1927 he moved again, this time to Centuria, where he practiced medicine until his death.

Doctor Noyes was a member of the Polk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Mrs. Anna B. Noyes; a daughter, Mrs. R. K. Dodge of Janesville; two sons, George B. of Milwaukee and Ralph B. of Spokane, Wash.; and a sister, Mrs. A. P. Brauer of Oshkosh.

Dr. Michael Robert Wilkinson, founder of the Wilkinson Clinic and Oconomowoc physician for over 55 years, died on March 15 at his Oconomowoc home. He was 88.

Doctor Wilkinson set up practice in Oconomowoc after his graduation from the Northwestern University Medical School in 1893. In 1929 he and his doctor-son Francis established the Wilkinson Clinic. Later three other sons, all doctors, joined the clinic.

Known throughout the area as "Dr. M. R.," Doctor Wilkinson was keenly interested in civic affairs. A member of county, state, and national medical societies, he once served as president of the Waukesha County Medical Society.

Doctor Wilkinson is survived by his wife, the former Mary Josephine Lingeman of Whitewater; five sons, Drs. J. Francis, John D., Donald D., and Philip M., his associates in the Wilkinson Clinic, and Dr. Clarence R., a professor in the modern language department of Marquette University; and two daughters, Helen, Oconomowoc, and Mrs. M. B. Byrnes, Wauwatosa.

"Dr. M. R."

Dr. M. R. is dead.

Those were the words which were spoken and respoken in Oconomowoc many times this week after this community lost one of its most esteemed citizens, Dr. M. R. Wilkinson, Sunday night. Death came to Oconomowoc's 88-year-old resident at his home on Pleasant Street after a long illness.

It was Oconomowoc he chose after graduation from medical school as the city in which to set up his practice nearly 60 years ago and it was to Oconomowoc and the surrounding area that he devoted a lifetime of service.

He was of the generation of physicians of the horse and buggy days who braved all types of weather and were faced with many inconveniences in ministering to the sick. Working night and day, traveling roads sometimes heaped with snow, at

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Post-Graduate Medical Institution in America)

EYE, EAR NOSE AND THROAT

A three months' combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuroanatomy; anesthesia; physical medicine; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics; attendance at departmental and general conferences.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both x-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media, such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, peri-renal insufflation and myelography. Discussions covering roentgen departmental management are also included.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2611 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.

PHYSICIAN AND HOSPITAL SUPPLIES

FOUR STORES

Complete Stocks Of Medical Specialties

Orders Filled Promptly

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting May 11, June 1, June 15
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 1
Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17
Gallbladder Surgery, Ten Hours, starting June 29
Surgery of Colon & Rectum, One Week, starting May 11
General Surgery, Two Weeks, October 12
Thoracic Surgery, One Week, starting June 8
Breast & Thyroid Surgery, One Week, starting June 22
Esophageal Surgery, One Week, starting June 22
Fractures & Traumatic Surgery, Two Weeks, starting June 15

GYNECOLOGY—Intensive Course, Two Weeks, starting June 15
Vaginal Approach to Pelvic Surgery, One Week, starting June 8

OBSTETRICS—Intensive Course, Two Weeks, starting June 8

PEDIATRICS—Congenital Heart Disease, Two Weeks, starting May 18
Cerebral Palsy, Two Weeks, starting June 15

MEDICINE—Gastroenterology, Two Weeks, starting May 18
Electrocardiography & Heart Disease, Two Weeks, starting July 13
Allergy, One Month and Six Months, by appointment

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks

DERMATOLOGY—Intensive Course, Two Weeks, starting May 11

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

other times almost impassable with mud, he served the length and breadth of the Oconomowoc area since the day in May of 1893 he "put out his shingle" at a small office on South Main Street. Many and many are the stories of his courage facing the ordeals of winter in those early days; many and many are the stories of his sacrifices to bring relief to a patient and family stricken with illness.

It was not only in his ministration to the sick that Dr. M. R. served well. It was to his community likewise. There was never any doubt of Dr. M. R's intense loyalty to the town which he adopted as his own. Anything concerning Oconomowoc was near and dear to him. He was instrumental in the formation of the Oconomowoc library, served many years on the school board, took an active interest in the business life of the city, was a loyal member of the American Legion, gave many years of service to the historical societies, believing that the preservation of the records of today were important to the citizens of tomorrow.

In the medical profession, too, he was active on both the county and state levels, serving as a past president of the Waukesha County Medical Society. St. Jerome's Church will always remember him as a loyal and devoted member.

Now that his life on this earth is ended, Oconomowoc pauses to pay tribute to a man who served well his profession, his community, and his God. (*Reprinted from the March 19 issue of the Oconomowoc Enterprise.*)

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Origin of Life and the Evolution of Living Things, An Environmental Theory. By Olan R. Hyndman, B.S., M.D., F.A.C.S. New York, Philosophical Library, 1952. Price $8.75.

The author sets forth a new and unique set of "concepts" of the "orders of differentiation of life," and of the significance of many biological phenomena such as haploidy, reproduction, multicellularity, and polar body formation. His first order is the "germ integer" or gene, apparently originating and evolving as essentially a part of the environment itself. It includes viruses and bacteria. The second order is the haploid cell, a group of "integers" integrated in a common cytoplasm which acts as the interphase between the "integers" and the environment, the centrosome acting as the coordinating "integer." The third order is the diploid cell (for example, Paramecium with its macro- and micronucleus) and most multicellular organisms, all considered diploid. Some of these ideas are surely original, and can even be correlated beautifully with certain biological entities, but as a rule the author ignores completely great masses of pertinent information, and resorts to series after series of totally unsupported statements to prove his hypotheses. These include the impression of heritable variations upon the organism by direct action of the environment, multiple and continued origin of organisms including all "orders of differentiation," and close resemblance of species having independent origins. The simple schemata and meticulous outlining should have made the author's concepts easy to grasp, but in spite of this the exposition is often completely incomprehensible, partly due to unsupported statements and partly due to queer diagram construction, queer use of symbols and almost continuous circumlocution. For instance, no one familiar with the problems of speciation could make any sense out of the discussion of natural selection on pages 302-303. Some things in a book of 648 pages are almost bound to be good; one can sympathize with some of the criticisms of the theory of evolutionary adaptation through chance mutations and natural selection, although biologists are already well aware of them. The "thesis," as the author calls it, has undoubtedly taken an enormous amount of thought and time, and certainly is ingenious, however illogical and unscientific it may be. The best statement the reviewer found in the book (p. 296), and one with which many will sympathize, describes the dilemma which prompted the author to this undertaking:

"I feel that most of those who have gazed at the beautifully adapted and awe-inspiring forms in nature and who have dreamed and pondered over how it all came about, would welcome a satisfying and acceptable explanation of the principle that adaptation is a direct response to the impress of environmental stimuli. Would there not be a deep sigh of relief in having exposed this real missing link and in having made the great story in the annals of natural history coherent?"—H.W.M.

The Clinical Use of Fluid and Electrolyte. By John H. Bland, M.D., assistant professor of medicine, University of Vermont College of Medicine. Philadelphia and London, W. B. Saunders Company, 1952. Price $6.50.

In an attempt to bring to the clinician a working knowledge of fluid electrolyte balance in health and disease, Doctor Bland has written a comprehensive and lucid volume on a subject of vital interest. Since the great discoveries in the field of biochemistry and physiology have been of such technical and highly specialized nature, the physician often has great difficulty in the interpretation and clinical application of this new information. The aim of this book is to provide a practical, usable guide to the recognition and treatment of the various fluid and electrolyte problems that may arise in medical and surgical patients.

Logically, the book is introduced by a chapter on certain basic physiological considerations; and such subjects as fluid compartments, units of chemical equivalence, respiratory and renal control of electrolyte patterns, and metabolic acidosis and alkalosis are treated. From this the author turns to the

matter of water and electrolyte balance in congestive heart failure, in renal disease, in diabetes mellitus, in adrenal cortical insufficiency, in pediatric patients, and in surgical patients. One chapter deals with the very important subject of normal and abnormal potassium metabolism. Of special significance, however, is the discussion of fluid and mineral balance in the geriatric patient. So little has been written about the physiology of the senescent organism, that we do not know how well the aged patient's compensatory mechanism functions in dealing with excess acid metabolites. Doctor Bland states that the proper administration of carefully selected repair solutions to geriatric patients will probably account for more lives saved than any other single therapeutic procedure in this group of patients. The concluding two chapters on the physiologic effects of ACTH and cortisone and on the behavior of body water and electrolytes in shock, burns, crush and blast injury, Roentgen irradiation, and exposure to cold help to bring the subject up to the minute and should be of particular interest to all practitioners.

By punctuating his material with frequent diagrams and illustrations, and by constantly emphasizing the clinical significance of his remarks, Doctor Bland enlivens a subject that might otherwise be tedious reading. This book is a valuable addition to the library of all physicians and particularly those who are interested in physiologic and pathologic mechanisms of fluid and electrolyte control.—R.R.

The Unipolar Electrocardiogram, A Clinical Interpretation. By Joseph M. Barker, M.D., F.A.C.P., cardiologist, Yater Clinic; associate professor of clinical medicine and special lecturer in physiology, Georgetown University School of Medicine; director of the Heart Station and visiting physician, Georgetown University Hospital; chief of cardiology, Providence Hospital; visiting physician, Gallinger Municipal Hospital; consulting cardiologist, Arlington Hospital, Arlington, Virginia. Assisted by Joseph J. Wallace, M.D., F.A.C.P., and advised by Wallace M. Yater, M.D., F.A.C.P. New York, Appleton-Century-Crofts, Inc., 1952.

This is a comprehensive treatise on the unipolar electrocardiogram and is the first to include the arrhythmias. The author does very well in interpreting the pioneer work of Frank N. Wilson. It is, however, his own sound ideas and meticulous simplicity that translate the electric and physiologic phenomena, peculiar to the electrocardiogram, into a logically understandable and relatively easy to read volume. The electrocardiographic illustrations, some enhanced by case studies, are very good. The worth-while diagrams, despite the attempt at brevity, still suffer in effectiveness because of the necessity of lengthy explanations.

Sound in its conception is the emphasis that the electrocardiogram needs correlation between history, physical findings and other laboratory aids for effectiveness, and long study and experience for proficiency.

Any one interested in electrocardiography should have this book.—H.H.S.

Biological Antagonism; The Theory of Biological Relativity. By Gustav J. Martin, Sc.D., research director, the National Drug Company, Philadelphia. Philadelphia, New York, and Toronto, The Blakiston Company, 1951.

This is an excellent reference book for investigators interested in pharmacology, physiological chemistry, nutrition, and other important biological fields. It reviews the tremendous amount of work done by fundamental investigators in the realm of enzyme chemistry in the hope that such a summary will lead to discoveries of chemotherapeutic agents of great value in medical science.—E.C.A.

Prescription for Medical Writing—A Useful Guide to Principles and Practice of Effective Scientific Writing and Illustrations. By Edwin P. Jordan, M.D., and Willard C. Shepard. Philadelphia and London, W. B. Saunders Company, 1952. Price $2.50.

This short initiation into the art of writing, especially medical writing, is written with great clarity and in an attractive style. The authors have incorporated the best advice given in this direction by other authors, and condensed an enormous amount of useful information into this small volume.—E.H.A.

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clyboum St. Milwaukee 3, Wisconsin

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

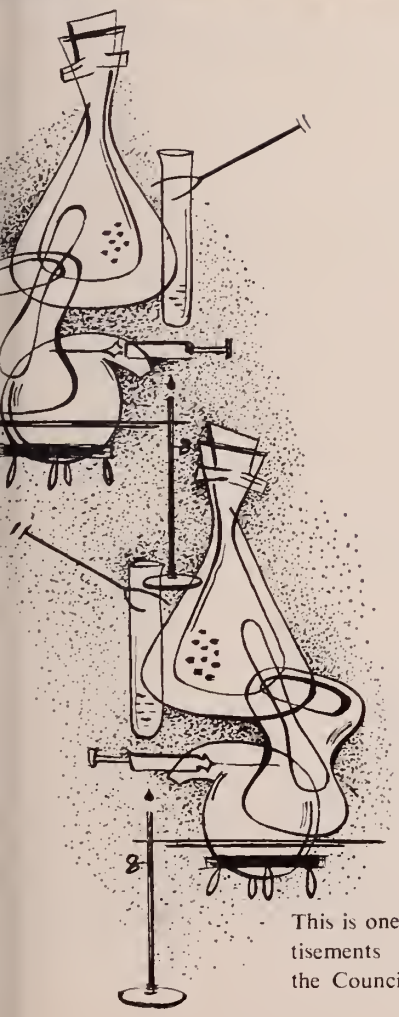
Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 Milwaukee, Wis.

What is the status of____?



Many times you have asked yourself, "Is the indicated drug Penicillin . . . Chloramphenicol . . . Aureomycin . . . Sulfadiazine . . . a combination . . . or what?" This same problem may confront you many times . . . not only with the antibiotics—but actually in any specific field where there are numerous drugs . . . and you are faced with the problem of determining which might be the therapy of choice for a given condition.

The need for such clarification has always been apparent to the Council on Pharmacy and Chemistry of the American Medical Association. Its frequent publication of special status reports in THE JOURNAL is designed to help answer such questions for you.

Information about new drugs—clinically proved indications . . . experimental uses . . . correct dosages . . . contra-indications . . . and similar facts—is frequently presented by the Council. Its announcements of newly accepted products also help keep you up-to-date on new and useful drugs. These notices which appear in THE JOURNAL almost every week can be a definite guide to you in knowing what preparations are Council accepted . . . how they are best used . . . and how they can be most effective in your daily practice.

Insistence on Council accepted products is one reliable guide to clinically tested products.

This is one of a series of advertisements designed to explain the Councils' functions to you.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

ACCEPTED COMMITTEE ON COSMETICS AMERICAN MEDICAL ASSOCIATION

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Complete office equipment of General Practitioner which includes examining table, instrument and drug cabinets, steel filing cabinet, sterilizer, scales, microscope, desk, chairs, book cases, etc., all in excellent condition. Doctor retiring because of ill health. Address replies to Dr. Edward Jackson, 931 W. Walnut St., Milwaukee, Wis. Phone Lo. 2–5144.

WANTED: General practitioner as associate in central Wisconsin. Excellent hospital facilities. Unlimited opportunity. Salary at first, partnership later. Address replies to Box 486 in care of the Journal.

FOR SALE: One 20 ma Profexray mobile x-ray unit, very reasonably priced. Also one Kelley Koett mobile x-ray unit, like new. Address replies to Downs X-Ray Company, 1004 N. Jackson St., Milwaukee 2, Wis. Phone BR. 2–7050.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor s needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE: One 20 ma Fischer x-ray mobile unit, bucky table, and other complete accessories. Excellent condition. Very reasonable. Address replies to Box 487 in care of the Journal.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

WANTED, otolaryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2–8118.

WANTED: Used hospital size Bovie Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5–9100.

PHYSICIAN WANTED as associate in busy, successful practice including surgery in rural, resort, and railroad town of 3,000 in northwest Wisconsin Indianhead region. Fully equipped 13-room modern brick clinic started April 15. Excellent hospital facilities near-by. Local hospital building campaign under way. Salary, percentage, or guaranteed minimum basis initially, with eventual partnership. Address replies to Lester J. Olson, M. D., Spooner, Wis.

WANTED: Physician as an associate in general practice, preferably with surgical training and service exempt. City of 10,000 population in north central Wisconsin, with excellent hospital facilities and on a salary basis with eventual partnership. Address replies to box 473 in care of the Journal.

WANTED: Pediatrician, or general practitioner willing to do large share of pediatrics, in an active group practice in suburban Milwaukee. Address replies to box 475 in care of the Journal.

FOR SALE: Hellige colorimeter for blood sugars, with glassware but no chemicals, $15. Also cystoscopy 3-cell battery box, $10. Address replies to R. M. Rogers, M. D., Tigerton, Wis.

PHYSICIAN WANTED, preferably one with one or two years experience in private practice, as an associate in a well established general and surgical practice in a city of over 30,000. Address replies to box 478 in care of the Journal.

PHYSICIANS AND PEDIATRICIANS, with or without public health training, needed in Maternal and Child Health program at salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Address replies to E. R. Krumbiegel, M. D., City Hall, Milwaukee, Wis.

CLINIC in Milwaukee needs general practitioner, internist, and pediatrician. Address replies to Box 488 in care of the Journal.

GENERAL PRACTITIONER, middle-aged with extensive experience, desires association or location. Available about June 1, 1953. Address replies to box 476 in care of the Journal.

WANTED: Urological table with built-in bucky. Must be relatively new and in good condition. Address replies to Milton Margoles, M. D., 1971 W. Capitol Dr., Milwaukee, Wis.

RADIOLOGIST with ten years' experience, Board certified, desires opportunity for group practice or contact with men interested in forming group. Address replies to Box 489 in care of the Journal.

LOCATION WANTED: General practitioner, age 28, married, family, desires assistantship, association, or location. Completing 24 months active duty in Army on April 1. Licensed in Wisconsin. Graduate of U. of Wisconsin Medical School. Has own office furniture and equipment. Address replies to box 481 in care of the Journal.

WANTED: Associate in general practice in a community of 30,000. Internist or well trained G.P. Percentage basis. Address replies to box 482 in care of the Journal.

ASSOCIATION WANTED: Physician who is tired of solo practice desires association with physician or group to do general practice. Address replies to box 483 in care of the Journal.

WANTED: Medical technologist, registered. Opportunities for research and advancement. Very pleasant working conditions. Thirty-five hour week. Address replies to Junior League Blood Center, 763 North 18th St., Milwaukee, Wis.

FOR SALE: Home and office combination in city of 1,000 in southern Wisconsin. Requires considerable investment but seller is willing to accept payment over a period of 10 to 15 years. Address replies to Box 490 in care of the Journal.

PHYSICIAN WANTED, preferably with education or experience in addition to the one-year internship, for a general practice which includes considerable surgery. Practice located in a central Wisconsin city of 5,000 with large drawing area and excellent hospital facilities. Arrangements for association open. Address replies to Box 491 in care of the Journal.

FOR SALE: One used GE, F–2, shock proof, wall model x-ray unit especially designed for taking sinus and mastoid x-rays. Every conceivable angle and stereos possible. Complete with modern hand timer, four 8 x 10 cassettes, and accessories, including a 3 gallon composition Buck tank. Address replies to W. G. Meier, M. D., Sheboygan, Wis.

LOCUM TENENS position wanted by hospital resident for several weeks beginning immediately. Address replies to Box 492 in care of the Journal.

EENT ASSISTANT wanted by certified otolaryngologist. Board eligible man in either specialty preferred; but will train young man and pay liberal salary. Permanent position. Good future. Address replies to Box 493 in care of the Journal.

WANTED: Locum tenens for the month of July or August. Address replies to H. Y. Fredrick, M. D., Westfield, Wis.

FOR SALE: Medium size autoclave (gas) very good condition, 2 water tanks and instrument sterilizer (one unit). Ideal for clinic or small hospital. Make offer. May be seen at 1403 N. Astor St., Milwaukee, Wis., by appointment. Call Broadway 1–1632.

UNUSUAL OPPORTUNITY to do general practice in Madison, Wis., as associate and later partner. Well established practice. Salary open. Address replies to Box 494 in care of the Journal.

WANTED: Young, progressive clinic in Wisconsin needs obstetrician and gynecologist, certified or Board qualified, and general practitioner. Excellent opportunities. Address replies to Box 495 in care of the Journal.

FOR SALE OR LEASE: Doctors' medical building in Marinette, Wis., suitable for combination clinic and living quarters. Excellent location. Community of 30,000. Hospital facilities. Active medical practice has been carried on at this location for over 50 years. Write to H. L. Jorgenson, M. D., 8163 N. E. Second Avenue, Miami, Florida.

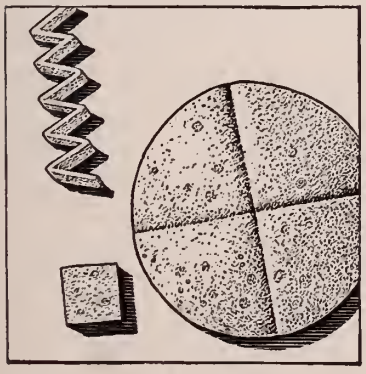
Upjohn

absorbable hemostat:

Available in a large variety of sizes and forms, including:

Surgical sponges
Compressed surgical sponges
Dental packs
Gynecologic packs
Nasal packs
Prostatectomy cones
Tumor diagnosis kit

The Upjohn Company, Kalamazoo, Michigan



Gelfoam

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Trademark Reg. U.S. Pat. Off. BRAND OF ABSORBABLE GELATIN SPONGE

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors -- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate -- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	6, 7, 31
American Meat Institute	18
Ames Company, Inc.	8
Ar-Ex Cosmetics	44
Audiphone Utilities	38
Ayerst, McKenna & Harrison, Ltd.	21
Barr X-Ray Company	48
Bayer Company	16
Benson Optical Company	37
Bergmann Prescription Center	27
Camel Cigarettes	17
Central Drug	27
Cook County Graduate School of Medicine	46
Doerflinger Artificial Limb Co.	4
Endocrine Laboratories	40
Hotel Schroeder	38
House of Bidwell	38
Hurley X-Ray Company	41
Ivanhoe Sanitarium	43
Keeley Institute	39
Kennedy–Mansfield	27
Knox Gelatin	42
Lederle Laboratories	facing page 18
Lilly, Eli and Company	22
Mallard, Incorporated	10
Mallatt Pharmacy	27
Mather Pharmacy	27
Mayer Drug	27
Mead Johnson and Company	55
Medical Protective Company	41
Merck and Co.	12
Milwaukee Sanitarium	56
New York Polyclinic	45
Orthopedic Appliance Company	48
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	15
Philip Morris	9
Physicians Casualty Association	35
Physicians and Hospitals Supply Co.	19
Professional Business Service	295
Purepac Corporation	4
Quincy X-Ray and Radium Laboratories	4
Radium Emanation Corporation	5
Rennebohm's	27
Rogers Memorial Sanitarium	56
Sacred Heart Sanitarium	46
St. Croixdale Sanitarium	5
Schering	29
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	37
Stanley, Inc.	45
Summit Hospital	35
Time Insurance Company	293
Upjohn Company	51
Wander Company	11
Winthrop–Stearns, Inc.	14
Wisconsin Life Insurance Company	40
Wyeth	13

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.

** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 JUNE 1953 Number 6

Hysteria in Poliomyelitis

By MAX J. FOX, M. D.* and IRWIN MOSKOWITZ**
Milwaukee Madison

IN CONSIDERING the differential diagnosis of a specific neurologic disease, the possibility of a hysterical paralysis should always be considered. During an epidemic of poliomyelitis many patients are admitted to the hospital with a syndrome which simulates poliomyelitis. Extensive laboratory studies such as cerebral spinal fluid examination, sedimentation rate, urinalysis, white blood cell count and differential, and red blood cell count and hemoglobin determinations are required in order to exclude this disease.

At the South View Isolation Hospital in Milwaukee many cases are admitted each year as suspected cases of poliomyelitis. During the 10 year period from 1942 through 1951, 36.9 per cent of the suspected poliomyelitis cases admitted were discharged because they were not poliomyelitis. Many of the individuals in this group had various types of neuroses. This paper presents case histories of 5 individuals admitted to South View Isolation Hospital because of a presumptive diagnosis of poliomyelitis in whom the hysterical syndrome was responsible for the symptomatology.

CASE 1—R. S., a 23 year old white male, was admitted to South View Isolation Hospital on May 20, 1952, with multiple complaints. His illness began on May 10, with the chief symptoms of tightness in the muscles of the back of the neck, low back pain, headache, nasal congestion, and cough. He also stated that he had had fever recently on several occasions with heavy sweats.

Physical examination at the time of admission revealed pharyngeal hyperemia with slight gray coating of the pharynx. The neuromuscular system was within physiologic limits. He had a temperature of 100 F. upon admission and a peak temperature of 101.6 F. about 12 hours after admission. Laboratory findings revealed the cerebral spinal fluid, urinalysis, white blood cell count and differential, and red blood cell count to be normal. The impression was an upper respiratory infection.

This patient had been reading newspaper reports of a probable pending epidemic of poliomyelitis. He was very anxious to know whether he did or did not have the disease. When he was informed that he did not, he felt so much better that he was able to get out of bed and dress himself, feeling well and able to perform all normal physical activities.

CASE 2—H. P., a 23 year old white female, was admitted to South View Hospital on May 19, 1952. Her illness began on May 18, 1952, with symptoms of stiffness and pain in the neck. The stiffness and pain in the back progressed and soon began to involve her legs. She then complained of a sore throat, difficulty in swallowing and breathing, and weakness of the neck muscles.

Physical examination revealed an afebrile, apprehensive patient. No muscle weakness was noted. There was questionable tenderness over the sacrospinalis and thigh musculature and abdominal muscle spasm. Reflexes were within physiologic limits. All other physical findings were also within normal range. Laboratory findings revealed the cerebral spinal fluid, total blood count (including red blood count, white blood count and differential, and sedimentation rate), and urinalysis to be normal.

The impression was hysteria.

The patient was discharged on May 20, 1952, in good condition.

This individual had been following the papers carefully in regard to poliomyelitis.

* Associate Professor of Clinical Medicine, Marquette University School of Medicine and Preceptor, University of Wisconsin Medical School.
** Senior Medical Student, University of Wisconsin Medical School.

When she related her symptoms to her family physician, he told her that she might have poliomyelitis. Soon she became convinced that all four of her extremities and her throat were paralyzed. After admission to the hospital, and after complete history and physical and laboratory studies, it was evident that she was suffering from hysteria. She was told that she did not have poliomyelitis and was not suffering from any central nervous system involvement. It was pointed out to her that she had normal sensory and motor function. Shortly thereafter she was able to sit up and use both arms and legs. She asked permission to be discharged from the hospital. We released her less than 24 hours after admission and she returned to her regular occupation the following day.

CASE 3—G. D., a 20 year old white male, was admitted to South View Isolation Hospital on May 13, 1952. He had experienced anorexia and nausea for one month before admission and had lost 10 pounds during this period. For the week before admission he had been having frontal headaches and pain in the posterior neck and lumbar region.

Physical examination revealed a well developed white male in no acute distress. Neurologic examination revealed no abnormalities. Mild hyperemia of the pharynx was noted. No other pertinent findings were present. Laboratory findings revealed a white blood cell count of 6,900 with normal differential, red blood cell count of 4,680,000 with hemoglobin of 14 Gm. per cent, normal sedimentation rate, and normal urinalysis.

The impression was pharyngitis with hysteria.

When this patient was informed by his family physician that he might have poliomyelitis, he became certain that his extremities were involved and that he would not be able to walk. Although careful examination revealed no isolated muscle group weakness, the patient's subjective efforts to raise his lower extremities revealed a negative effort on his part to sustain his lower limbs on active or passive leg raising. After 24 hours of hospitalization, we were convinced that the patient was suffering from hysterical muscle paralysis and informed him that he did not have poliomyelitis. Shortly thereafter he sat up in bed and asked for bathroom privileges, whereupon we gave him his clothes and he walked out of the hospital, resuming his regular occupation on the following day.

CASE 4—R. L., a 44 year old white male, was admitted to South View Hospital on May 15, 1952. He complained of a sore throat one week before admission with the onset of weakness and stiffness in both legs two days before admission, but he had continued to work. Weakness in both arms developed the day before admission.

Physical examination was essentially negative. Laboratory reports revealed a white blood cell count of 12,850 with normal differential, red blood cell count of 4,620,000 with hemoglobin of 14 Gm. per cent, normal cerebral spinal fluid, and normal urinalysis. Sedimentation rate was 30 mm. per hour.

This patient had called his family physician while at work in his filling station. The physician noted spasm in his back muscles, weakness of the lower extremities, and a normal temperature, and he told the patient that he might have poliomyelitis. As soon as the patient was told this, he lost complete control of both the upper and lower extremities.

Physical examination at South View Hospital revealed no evidence of neuromuscular dysfunction. We informed him that there were no positive findings. He continued to complain of inability to move any of his extremities. At that time we informed him that he did not have poliomyelitis, but he said that he could not raise his arms to feed himself or lift himself off his bed. One of us told him, "If you don't help yourself in eating, you will have to starve." After leaving the room we observed him through a glass partition. He gradually sat up and began to feed himself. Shortly thereafter, we re-entered the room and he stated, thankfully, that he was able to use his arms in feeding himself and his legs in getting up in bed. This patient was transferred to the care of a neuropsychiatrist in a private hospital. After three days of further hospitalization, the attending neuropsychiatrist called back and concurred in the diagnosis of hysteria. This patient was able to walk out of the hospital after a short period of intensive psychiatric treatment. On rechecking all of his laboratory tests, we still found no evidence of organic or infectious disease in this individual. He is again carrying on his regular occupation as a garage mechanic.

CASE 5—Mrs. F. L., a 37 year old white female, was admitted to South View Hospital on Sept. 7, 1945. She was transferred from an out-of-town hospital to South View Hospital as a potential poliomyelitis case. The

community in which she resided was in the midst of a poliomyelitis epidemic and this woman assumed that she was infected with the disease. Her illness began with chills, a temperature of 100 F. and pain and stiffness in her neck. Pulse rate and respiratory rate were normal. A careful survey of the neuromuscular status revealed no positive findings. Abdominal and gynecologic examinations were negative. Laboratory reports revealed white blood cell count of 5,700, red blood cell count of 4,600,000, and hemoglobin of 8.6. Cerebrospinal fluid revealed 14 cells per cc., 96 per cent of which were lymphocytes and 4 per cent polymorphonuclear leukocytes. Dextrose was 53 mg. per cent, chloride 726 mg. per cent, and total protein 30 mg. per cent.

The febrile state persisted for 72 hours, after which the temperature dropped to normal. The complaint of severe headache persisted for 24 hours. When the patient was informed that she was a questionable case of poliomyelitis, she suddenly stated that she was unable to see and could not recognize anything placed before her eyes. Ophthalmologic counsel was sought but no apparent abnormalities were revealed.

The impression of functional blindness on a hysterical basis was apparent. The ophthalmologist recommended encouragement and early transfer home. Before dismissal the patient was informed that she did not have poliomyelitis. Immediately thereafter she was able to see objects placed before her and within a short period of time was able to get out of bed and ask for her clothes. She was discharged in an improved condition seven days after admission.

The accompanying tables show the total suspected poliomyelitis admissions from 1942 through 1951 with the number of non-poliomyelitis cases and proved cases of poliomyelitis. Table 1 presents the yearly totals; table 2 presents these figures on a percentage basis; table 3, the cumulative totals; and table 4 presents the cumulative total presumptive poliomyelitis admissions and the percentage of poliomyelitis cases and non-poliomyelitis for these years.

As is noted in table 4, a high percentage (36.9 per cent of 2,793 cases) of suspected poliomyelitis admitted during this 10 year period from 1942 through 1951 were discharged as non-poliomyelitis cases. Of the cases discharged as non-poliomyelitis, 65 per cent had their actual illness subsequently diagnosed by their family physicians as an acute infectious disease rather than poliomyelitis. It is not the purpose of this paper to discuss the problems that may be interlocked in the differential diagnosis of poliomyelitis.

Out of 34 cases of suspected poliomyelitis admitted to the Isolation Hospital in Omaha, Nebraska, Young[1] reported 4 cases of hysteria. These cases, like the 5 presented in this paper, were not associated with concomitant poliomyelitis infection, and the hysterical state of the patient was the sole mechanism for the paralysis. Young and Hermann[2] reported a case of poliomyelitis occurring in a patient suffering from a concurrent hysterical paralysis.

Cameron[3] defines hysterical paralysis as "the persistent partial or complete loss of specific motor activity as a reaction to need or anxiety, in the absence of organ or tissue pathology adequate to account for it." He defines hysterical anesthesia as "the persistent partial or complete loss of response to stimulation of a surface area as a reaction to need or anxiety, in the absence of organ or tissue pathology adequate to account for it."

During periods of emotional stress or anxiety, patients may become paralyzed. Not only do they say that they are unable to move their limbs, but they actually show great limitation in an active or passive motion.

It becomes quite evident when reviewing the accompanying tables that 1 out of every 3 patients admitted to our Isolation Hospital during the years 1942 through 1951 with the presumptive diagnosis of poliomyelitis was discharged as a non-poliomyelitis case. A great number of the non-poliomyelitis cases are sent in chiefly because of fear of poliomyelitis. This fear is brought out chiefly by the publicity given to the disease during the summer months. Newspapers, radio, TV, and mouth-to-mouth discussion of poliomyelitis by lay people tend to create fear and anxiety in the public mind; and individuals with a background of pre-existing conflicts or needs find the development of poliomyelitis paralysis a convenient technic for disposing of the tensions of need and anxiety.

The factors involved in hysterical amaurosis, as noted in the patient discussed in case 5, are similar to acute emotional dis-

tress or fears on a background of tensions of anxiety and unsatisfied need. When hysterical amaurosis does occur there will be associated normal pupillary reflexes and extraocular movements as noted in this patient. We have had other similar cases and are using this as an illustrative case.

In considering the differential diagnosis of hysteria and poliomyelitis, the cerebral spinal fluid examination in hysteria reveals normal cell count and protein values. The history is very important in the diagnosis of hysteria, for, if adequately taken, one will discover basic anxieties and conflicts underlying an illness which has been set off by an acute emotional distress. Young[4] states that patients with poliomyelitis usually have few recurring anxieties during their acute illness, while patients suffering from hysterical paralysis will have more evidence of emotional disturbances. Physical examination in patients with hysterical paralysis reveals decrease or absence of the gag reflex and corneal reflex.

Summary and Conclusions

1. Five cases of hysterical paralysis considered as suspected poliomyelitis during the poliomyelitis season are presented.

2. Tables reviewing the percentage of non-poliomyelitis cases out of the total poliomyelitis admissions to the South View Isolation Hospital for the 10 year period 1942 through 1951 are presented.

3. A discussion of the mechanisms involved in hysterical paralysis is presented.

4. Several factors to be considered in the diagnosis of hysterical paralysis, particularly during a poliomyelitis epidemic, are mentioned. The most important of these are cerebral spinal fluid examination, adequate history, and physical examination.

5. During the season of a poliomyelitis epidemic the likelihood of hysterical paralysis should be considered by the general practitioner.

(M. J. F.) 324 East Wisconsin Avenue.

REFERENCES

1. Young, R. H.: Clinical syndrome simulating poliomyelitis, New England J. Med. 236:794–795 (May 22) 1947.
2. Young, R. H., and Hermann, H. T.: Hysterical paralysis associated with poliomyelitis, J. A. M. A. 147:1132–1133 (Nov. 17) 1951.
3. Cameron, N.: The Psychology of Behavior Disorders, Boston, Houghton–Mifflin, 1947, p. 327.
4. Young, R. H.: The patient's attitude toward poliomyelitis, Ment. Hyg. 33:262–270 (April) 1949.

TABLE 1—*Yearly Totals of Poliomyelitis Suspect Admissions 1942–1951 (Poliomyelitis Cases and Non-poliomyelitis Cases)*

Year	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951
Total Suspected Poliomyelitis Admissions	20	58	117	212	287	134	438	340	352	835
Actual Poliomyelitis Cases	11	44	83	134	217	81	275	180	236	499
Non-poliomyelitis Cases	9	14	34	78	70	53	163	160	116	336

TABLE 2—*Yearly Totals of Poliomyelitis Suspect Admissions 1942–1951 (Percentage of Poliomyelitis Cases and Non-poliomyelitis Cases)*

Year	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951
Total Suspected Poliomyelitis Admissions	20	58	117	212	287	134	438	340	352	835
Actual Poliomyelitis Cases	55%	76%	71%	63%	76%	60%	63%	53%	67%	60%
Non-poliomyelitis Cases	45%	24%	29%	37%	24%	40%	37%	47%	33%	40%

TABLE 3

Total Suspected Poliomyelitis Admissions 1942–1951	2,793
Total Actual Poliomyelitis Cases 1942–1951	1,760
Total Non-poliomyelitis Cases 1942–1951	1,033

TABLE 4

Total Suspected Poliomyelitis Admissions 1942–1951	2,793
Actual Poliomyelitis Cases 1942–1951	63.1%
Non-poliomyelitis Cases 1942–1951	36.9%

Present Concepts of Poliomyelitis

A Review of Recent Literature

By MARGARET PROUTY, M. D.*
Madison

AS WE approach the critical season of poliomyelitis, it seems appropriate to summarize present concepts concerning this disease so that the physician will be spared the time-consuming research for literature necessary to keep himself informed. No original work is introduced; this will serve simply as an index to recently published reports.

Etiology

Poliomyelitis virus can be separated into three broad antigenic groups: Brunhilde (Type 1), Lansing (Type 2), and Leon (Type 3). Type 1 is predominant, with 85 isolated strains; Type 2 has 12 strains; and Type 3 has 3 strains. The discovery that tissue cultures may be more reliable than primates for virus growth has been a significant advance.[1]

Epidemiology

More than one type of poliomyelitis virus may be present in a single epidemic in a community,[2] and it is thought that second attacks of the disease in the human being are due to reinfection with a different type of antigen.

Virulence may vary among strains in one type, some stimulating the formation of antibodies in monkeys more readily than other strains. Pathogenicity may be reduced by repeated cultivation in vitro,[3] but it has yet to be determined whether long-continued passage will lead to a nonpathogenic strain that retains its antigenicity.

It appears that different virus types give rise to different clinical pictures with powers to paralyze in one case and to immunize in another. During epidemics, the greatest number of nonfatal cases are of the Brunhilde type, whereas strains isolated from the fatal cases are largely Lansing. The Lansing type appears to produce relatively less paralytic poliomyelitis. No epidemic of Lansing strain type has been confirmed, yet the strain is extremely common and must be all about us. The fundamental question arises as to cross-immunologic relationships between strains of the Lansing group and other strains of poliomyelitis virus. Is it possible that repeated exposures to members of the Lansing strain can give rise to polyvalent immunity?

It is generally accepted that the source of the virus is the feces of patients and healthy carriers, the virus being ingested into the gastrointestinal tract where it spreads into regional lymph vessels emptying into the blood stream. Horstmann[4] has demonstrated the recovery of virus from the blood streams of primates on the fourth to sixth day after the oral ingestion of both Brunhilde and Lansing types. The interval between this viremia and subsequent paralysis varied from three to seven days. Bodian[5] confirmed these findings and indicated that virus multiplication may take place in three stages —in the alimentary, vascular, and neural systems.

Virus is repeatedly discovered in flies during outbreaks of poliomyelitis, and from 80 to 90 per cent of cases in temperate zones occur during the fly season. Virus may be detected in the excretia of flies between the fourth to tenth day after eating infected human stool. It has been suggested that the insects may become a source of food contamination several miles away because of survival of the disease in dried excrement for one or two days.

Both Coxsackie virus and poliomyelitis virus may occur in the same epidemic, as well as in the same individual. At present Coxsackie viruses are classified into Groups A and B. Group A strains are recovered from children with a history of brief acute illness, high fever, and headache. Concurrently, vesicles are observed over the soft palate and pharynx, and small punched-out pharyngeal ulcers suggest herpangina.[6]

Group B strains are found in patients who have epidemic pleurodynia ("devil's grip") and aseptic meningitis. Epidemics of this

* Department of Pediatrics, Jackson Clinic, Madison, Wis.

type occur in summer principally among children and young adults; the disease is benign and short-lived.

When both Coxsackie and poliomyelitis viruses are recovered from the same patient and when Group A is the accompanying strain, the incidence of paralysis is much higher than when Group B is involved. The theory has been postulated that Group A may tip the balance in favor of paralysis, whereas Group B may limit the spread of the poliomyelitis virus in the body. At any rate the incidence of paralytic poliomyelitis has been observed to be low during an outbreak of pleurodynia.

In general, our beliefs regarding poliomyelitis have undergone drastic change in the last few years. Instead of limitation to temperate climates, Paul,[7] in summarizing the proceedings of the Second International Poliomyelitis Conference, points out that most tropical areas where studies have been made show no dearth of Lansing antibodies, even among infants of 1 or 2 years. More than half the infants had acquired antibodies by the age of 14 months, and throughout subsequent life the level was maintained at about 100 per cent. This suggests heavy exposure to an agent which has the capacity of giving rise to an antibody, and with such early exposure the number of susceptible individuals seldom becomes large enough to give rise to an epidemic.

The generalization has been made that since poliomyelitis appears to be associated with filth, less early immunity is acquired as the economic level rises. In the United States, England, and the Scandinavian countries more virulent cases are appearing in older age groups. We no longer regard it as a disease of infancy.

Originally considered only mildly contagious, poliomyelitis is now known to be one of the most contagious diseases—probably on a par with measles. It was originally thought to be limited to acute paralysis, but we know now that paralysis occurs in only 1 out of 100 cases, or possibly only in 1 out of 1,000. Rather than being endemic, it is epidemic.

Prophylaxis

Sabin[8] has formulated simple rules for protection during epidemics:

1. Keep fingers out of the mouth, and wash hands before eating.
2. Keep flies away from all food, and thoroughly wash whatever is to be eaten uncooked, such as fruit and vegetables.
3. Keep children under 16 years out of crowded public wading and swimming pools.
4. Avoid intimate association, including hand shaking, kissing, and use of common eating utensils or towels, with members of a family in which poliomyelitis has occurred within three weeks, even if the patient has been removed to a hospital.

Sabin thinks that it is unnecessary to advise such measures as avoidance of crowds, closing of schools, and banning of suspected patients from general hospital wards. The alimentary tract is the only place other than neural tissue where virus is regularly found. It is seldom recovered from the nose and respiratory spray; therefore, the virus is largely stool-born.

Gamma globulin is of benefit in the prophylaxis of polio.[9] This prophylaxis is not complete, however, and is lost after approximately five weeks. It appears to be without benefit after the disease has been contracted.

Gamma globulin is considered to be of value only from pooled serum. One pint supplies an average of 7 cc. The dosage depends upon the weight of the child and is given in doses of 4, 7, and 11 cc.

The objection has been heard that since a child is thought to develop immunity when polio is prevalent in the community, the use of gamma globulin might prevent the development of active immunization. This objection, however, is entirely theoretical; on the other side of the picture, it has been suggested that eventually gamma globulin may be combined with a vaccine so that active immunity may be produced under the protective passive effects of the gamma globulin.

The true solution lies in the development of an active immunization by means of a vaccine. Koprowski[10] reported on 20 volunteers who were fed living poliomyelitis virus attenuated by passage through cotton rats. After oral administration of the virus most of the volunteers manifested a carrier state characterized by excretion of virus in their stools. Antibodies promptly developed in the blood of the now-immune volunteers. No volunteer showed illness.

Further progress in the development of a vaccine was reported by Salk,[11] who inoculated virus of each of the three immunologic types into the testicular and kidney tissue

of monkeys. The cultures were rendered non-infectious by treatment with formaldehyde, and incorporated in a water-in-oil emulsion for injection into human volunteers. These subjects showed a significant rise in titer of antibody against all three types of virus, a response adequate to provide significant protection against paralysis of the naturally acquired infection.

The development of a satisfactory vaccine is awaited with eagerness. Meanwhile there is need for a practical test, analogous to the Schick test, to distinguish the immune from the non-immune. Until such a test is available, gamma globulin will be wasted on many children already immune. If the complement fixation test of Casals[12] shows value in further clinical trials, the diagnosis of confusing cases will be simplified.

Factors Enhancing Paralysis

Anderson[13] has reported that the danger of poliomyelitis was three times as great among persons who had undergone tonsillectomies within one month before exposure to the virus as among a control group not subjected to surgery. The danger of the bulbar type was 11 times as great. On this basis, elective surgery is usually postponed until after the poliomyelitis season. Indeed, Top[14] attempts to show a higher incidence of paralytic poliomyelitis in those who have had tonsillectomies at any previous time in life. However, his findings have not been generally accepted or rechecked.

Investigation of a possible relationship between inoculation and poliomyelitis was made by the Public Health Service. Under its sponsorship and assisted by the National Foundation of Infantile Paralysis, a meeting was held of 42 poliomyelitis investigators, epidemiologists, pediatricians, allergists, and health officers.[15] The group was of the opinion that there was no increase in the incidence of poliomyelitis as a result of injection; however, there was some indication that injections for prevention of diphtheria, pertussis, and possibly tetanus, when given during an epidemic phase of poliomyelitis, may on rare occasions localize the paralysis to the recently inoculated extremity. As a result of this conference, conclusions were formulated which have been transmitted to the medical profession and to the public:

"There is no definite evidence that an increase in the number of cases of poliomyelitis has occurred as a result of injections of vaccines, drugs, and other medicinal agents. There is evidence that injections for the prevention of diphtheria, whooping cough and possibly tetanus, when given during an epidemic of poliomyelitis, may, on rare occasions, localize the paralysis in the inoculated arm or leg. There is no satisfactory evidence that other types of injections have any effect on the localization, frequency or severity of poliomyelitic paralysis. In the small number of persons with localization of paralysis in the inoculated limb, the injections, for the most part, were given about 7 to 21 days prior to onset, which corresponds to the usual incubation period of poliomyelitis. This has raised the question as to whether or not inoculated persons have a greater chance of contracting poliomyelitis during an epidemic.

"There is as yet no final answer to this question, but it is a fact that, even if there should be an increased chance, it is extremely small. Many thousands of poliomyelitis cases occur every year among children who have not had any injections during the preceding few months, and thousands of children have received injections for whooping cough, diphtheria and tetanus during poliomyelitis epidemics and have not developed the disease.

"Diphtheria, tetanus and whooping cough are serious diseases which can be prevented by immunization. Unchecked, these diseases present a far greater hazard than poliomyelitis. The benefits derived from immunization against these diseases far outweigh the questionably small increased chance of contracting poliomyelitis. However, even this questionable risk can be avoided by carrying out these immunizations when poliomyelitis is not epidemic in the community. There appears to be no good reason for withholding these immunizations during the summer months in communities that are not having an epidemic of poliomyelitis.

"Furthermore, poliomyelitis is at all times so rare in infants under 6 months of age, and the danger from other infectious diseases, particularly whooping cough, is so great, that it is advisable to continue the immunization procedures for this age group even during a poliomyelitis epidemic. In adults also, poliomyelitis is relatively so infrequent, that when there is a need for

immunizing or therapeutic injections, such injections should not be withheld.

"Certainly no parent should object and no physician should hesitate to administer a needed antibiotic, drug or other injection for treatment of disease at any time. When there is immediate danger from diphtheria, whooping cough or tetanus, the preventive inoculations should be given to all threatened age groups even during a poliomyelitis epidemic. In the final analysis the decision as to when an immunizing or therapeutic injection shall be given to an individual patient must rest with the physician."

Unaccustomed physical activity at the time of the onset of poliomyelitis was studied by Horstmann, who found that such activity during the first brief phase of onset had no effect. During the acute febrile stage of the illness, however, unusual exercise clearly enhanced the incidence of paralytic severity.

Anderson reviewed the attack rate in pregnant and nonpregnant women and found the incidence in pregnancy to be 27 per cent higher than in the nonpregnant, although there was no greater severity of infection among the former.

Observation has been made by Shwartzman[16] that ACTH and cortisone in combination or cortisone alone will produce a marked enhancement of poliomyelitis in mice marked by increased severity of symptoms, shortening of the incubation period, reduction in survival time, and high mortality rate. Repeated in primates with similar findings, it appears best to withhold this medication during the polio season until human studies can be completed.

Harrington[17] found that trauma or injury predisposes to paralysis, and in each case the paralysis appeared in muscles related to the site of trauma.

Diagnosis

Since there are no practical specific diagnostic aids, the diagnosis largely depends upon history and knowledge of epidemiologic features of the disease. The infection appears principally between the months of May to October and tends to affect children more commonly than adults, although there is an increased incidence in the latter.

The incubation period ranges from 3 to 36 days, although a history of exposure is usually difficult to obtain. Prodromal symptoms may be of three types: (1) pharyngeal—slight sore throat, fever, and redness of the throat membranes; (2) gastrointestinal—fever, nausea, vomiting, constipation, and occasionally diarrhea; and (3) "flu-like" symptoms of muscular aching with fever.

A diagnosis of abortive polio is no longer made, and we now recognize two types of disease, the nonparalytic and the paralytic.

I. The nonparalytic form is common and often not recognized except by laboratory observations. The spinal fluid cell count varies from 50 to 300 per cubic millimeter and is highest during the first week; in about 10 per cent of cases the cell count remains normal. Usually there is early predominance of mononuclear cells, although neutrophils may be numerous at first. The protein content is often normal or low during the first days, rises during the second to fourth week, and subsides slowly, usually reaching normal by the tenth week. If the physical findings and progress are suggestive of this infection, a positive spinal fluid cell count helps to confirm the diagnosis but does not rule it out if missing.

II. Paralytic poliomyelitis is divided into spinal, bulbar, and encephalitic types. The onset is as described above, but paralysis may appear suddenly. Occasionally the fever is high during the prodroma and again at the onset of muscle weakness. There are usually signs of meningeal involvement, and positive spinal fluid findings are usually present.

A. *Spinal Type*

1. The temperature is usually elevated the first few days. Thereafter, if it remains normal for at least 48 hours, there is seldom further extension of paralysis.

2. Patients frequently complain of cramping discomfort in muscles before paralysis appears. Pain may be severe and spasm detectable. Muscle weakness may appear slowly or rapidly with complete involvement of all muscles within 48 hours. Rarely a rapidly ascending (Landry's type) paralysis occurs.

3. Muscle dysfunction depends entirely upon the portion of cord involved. Any part or combination of the spinal cord divisions may be affected, although the lumbar area is most often damaged.

4. Abdominal cramps and constipation are common complaints and are caused by both weakness of the abdominal muscles and by paralytic ileus.

B. *Bulbar Type*

1. Spasm of the neck, back, and hamstrings is nearly always present.

2. Any of the cranial nerves (except N.I) may be involved. The type of paralysis depends upon the function of the nerve involved. The most common involvement is that of N. IX and N. X (with interference of swallowing) and N. VII (with facial paralysis), and N. III, IV, or VI (with extra-ocular muscular weakness).

3. Involvement of the medullary center may cause loss of the ability to swallow, while interference with breathing will affect rate, rhythm, and depth of respiration. As the infection progresses, breathing becomes more shallow with longer periods of apnea until respiration ceases entirely.

4. Hiccoughing is frequently present. The lips may be cherry red and the skin flushed as the circulatory mechanism is impaired. At first, temperature, pulse rate, and blood pressure are elevated but terminally reach shock levels. Anxiety and confusion accompany failure of circulation. The heart usually ceases before respiration does.

C. *Polioencephalitis*

1. Diffuse form: Patients are apprehensive and express a feeling of impending doom. Fatal cases exhibit confusion and lethargy. Twitching and jerking of facial muscles and extremities and tremor of the hands may be present. Insomnia may be severe.

2. Focal form: Grand mal convulsions, spastic hemiparesis, ataxia involving one arm or leg, and hydrocephalus have been described.

Therapy

Polio presents such a variety of therapeutic problems that no attempt will be made to present all the methods of therapy. In general, treatment is used which will control pain, ease muscle spasm, preserve function, prevent deformity, alleviate the tension of emotional strain, and, in the severely ill, save life.

It is no longer thought that the milder forms need be hospitalized, for emotional disturbance is much less within the sympathetic, familiar surroundings of family life.

In conclusion, we must bear in mind that the successful therapy and rehabilitation of any patient is the responsibility of the total team—the pediatrician or internist, orthopedist, neurologist, psychiatrist, social worker, physiotherapist, occupational therapist, and nurse. All patients who have had polio from the mildest to the most severe form should be followed for at least two years after onset, for it is during this time that new weaknesses may be detected, corrections instituted, and emotional disturbances alleviated.

---

16 South Henry Street.

REFERENCES

1. Ward, R.: Some recent advances in poliomyelitis research, Am. J. Phy. Med. 31:206–214 (Aug.) 1952.
2. Bodian, D.: Second attacks of paralytic poliomyelitis in human beings in relation to immunity, virus types and virulence, Am. J. Hyg. 54:174–190 (Sept.) 1951.
3. Robbins, F. C., and others: Studies on the cultivation of poliomyelitis viruses in tissue culture, Am. J. Hyg. 54:286–293 (Sept.) 1951.
4. Horstmann, D. M.: Poliomyelitis virus in blood of orally infected monkeys and chimpanzees, Proc. Soc. Exper. Biol. & Med. 79:417–419 (March) 1952.
5. Bodian, D.: A reconsideration of the pathogenesis of poliomyelitis, Am. J. Hyg. 55:414–438 (May) 1952.
6. Kilbourne, E. D.: The Coxsackie viruses and human disease, Am. J. M. Sc. 224:93–102 (July) 1952.
7. Paul, J. R.: Current knowledge and trends in poliomyelitis, Merck report, Jan. 1952.
8. Sabin, A. B.: Transmission of the poliomyelitis virus, J. Pediat. 39:519–531 (Nov.) 1951.
9. Veeder, B. S.: The gamma globulin polio problem, J. Pediat. 42:273–275 (Feb.) 1953.
10. Koprowski, H., Jervis, G. A., and Norton, T. W.: Immune responses in human volunteers upon oral administration of a rodent-adapted strain of poliomyelitis virus, Am. J. Hyg. 55 108–126 (Jan.) 1952.
11. Salk, J. E.: Studies in human subjects on active immunization against poliomyelitis; 1. A preliminary report of experiments in progress, J.A.M.A. 151:1081–1098 (March 28) 1953.
12. Casals, J., and Olitsky, P. K.: A specific complement fixation test for poliomyelitis, Proc. Soc. Exper. Biol. & Med. 75:315–318 (Nov.) 1950.
13. Anderson, G. W., and others The risk of poliomyelitis after tonsillectomy, Ann. Otol. Rhin. & Laryng. 59:602–613 (Sept.) 1950.
14. Top, F. H.: Occurrence of poliomyelitis in relation to tonsillectomies at various intervals, J.A.M.A. 150:534–538 (Oct. 11) 1952.
15. Relationship between inoculations and poliomyelitis (editorial), J.A.M.A. 149:170 (May 10) 1952.
16. Shwartzman, G.: Enhancing effect of cortisone upon poliomyelitis infection (strain MEF1) in hamsters and mice, Proc. Soc. Exper. Biol. & Med. 75:835–838 (Dec.) 1950.
17. Harrington, A. B.: Paralytic poliomyelitis following injury, Lancet 1:987–988 (May 5) 1951.

Acute Pneumonia

An Appraisal of Six Months' Experience at Veterans Administration Hospital, Wood, Wisconsin*

By REUBEN BEEZY, M. D., Wood, MARK J. CICCANTELLI, M. D., Wood
and WILLIAM J. SMILES, M. D. Ashland

THE use of modern antimicrobial agents in the therapy of pneumonia has resulted in a changed concept of this disease. In this paper, we are reporting our experiences with 85 pneumonia patients who were admitted to the pulmonary disease service at the Veterans Administration Hospital, Wood, during the first six months of 1952. The patients were all male veterans, some of whom lived at the hospital domiciliary because of established chronic disabilities. From this series we have omitted all cases initially diagnosed as pneumonia but subsequently proved to be pulmonary carcinoma, pulmonary tuberculosis, and other unrelated chest diseases.

Our most significant observations will be considered under three aspects. First, we shall deal with the etiologic types of pneumonia which were seen. Second, we wish to describe the usual course in those cases achieving the optimal therapeutic response. Finally, we are reporting the complications which were encountered, and insofar as determinable, attempting to relate them to contributory factors in their causation.

Method

All of our patients underwent at least the following diagnostic procedures before therapy: chest x-ray, blood culture, and examination of a specimen of fresh sputum. Complete blood count and sedimentation rate were obtained either simultaneously with the above or within the first 12 hours after admission. Sera were tested during the acute and convalescent stages for cold and Streptococcus MG (McGonigal) agglutination titers whenever a diagnosis of virus pneumonia was suspected.

After the initial studies, the patients were followed by weekly chest x-rays, blood counts, and tests of erythrocyte sedimentation rate. Blood cultures, when initially positive, were repeated daily until no growth was reported. In most of the patients, at least one sputum was examined by smear and culture for tubercle bacilli.

All of the patients were treated either with procaine penicillin or Aureomycin. Occasionally the aqueous form of penicillin was given at 3 hour intervals. In some cases a switch was made from one antibiotic to another when the course seemed unsatisfactory. The dosage of penicillin was 300,000 units twice daily at 12 hour intervals; the first dose of Aureomycin was 500 mg. and thereafter a maintenance dose of 250 mg. was given at regular 6 hour intervals. Antibiotics were discontinued when there was no clinical, laboratory, or x-ray evidence of further infectious activity.

Specific Etiology

Of the 85 patients, 54 were found to have pneumococcus in the sputum (in 12 of these, the blood culture was also positive). Of the remainder, 10 were found to have Streptococcus, 2 Staphylococcus, and 18 exhibited a mixed flora in their sputa. There was 1 case of virus pneumonia (psittacosis) established by a diagnostic agglutination titer. There were no instances of Friedländer's or Hemophilus influenza pneumonia. The paucity of cases of virus origin was unexpected and cannot be explained.

The Course of Favorably Responding Pneumonia

The following generalizations can be made concerning the clinical course of the patients who responded favorably. In this group, which numbered 65 cases, fever and symp-

---

* From the Veterans Administration Hospital, Wood, Wisconsin, and Marquette University School of Medicine, Milwaukee, Wisconsin.

Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.

toms showed rapid remission, resolution progressed satisfactorily, and no complications ensued. These patients became and remained afebrile at some time between the first and sixth days after the start of treatment.

Disappearance of cough, expectoration, chest pain, malaise, and dyspnea was usually evident between the second and eighth day of treatment. Roentgenographic abnormalities persisted for a period ranging from 5 to 14 days.

Laboratory evidence of improvement was reflected in the return of the white blood cell count to normal by the fifth day, and a normal or stabilized erythrocyte sedimentation rate by the end of the second week.

Complications

In spite of modern therapeutic agents the complications of pneumonia continue to present a problem.[1-4] In our series, complications were noted in 20 cases, or 23.5 per cent. Delayed resolution was present in 9 cases, massive pleural effusion developed in 6, extension of the disease in 3, and empyema in 2. Only those cases which revealed little or no resolution of their disease by x-ray after two weeks of therapy were considered to have delayed resolution. Pleural effusion was considered to be a complication when it was of sufficient quantity to require thoracentesis. Extension of the disease process was considered a complication when those patients under therapy had a spread of the disease to another lobe of the lung. The diagnosis of empyema was made on the basis of the finding of purulent effusion at thoracentesis.

We feel that the reason for the occurrence of complications is more likely to be related to the lack of resistance of the host than to the virulence of the organism. Significant factors in reducing this resistance are the age of the patient, the duration of the patient's illness before treatment, pre-existing pulmonary or other disease, and associated bacteremia. We thought it significant that in our series of cases the incidence of complications in patients under 40 years of age was about one half that in patients beyond the age of 40.

Another significant factor in reducing the resistance of the host is the duration of illness before therapy.[3] We found that in those patients who had been ill three days or longer before the institution of therapy the incidence of complications was increased almost threefold. Another factor studied was the relationship of coincidental disease to complications. We have observed that in those patients with alterations of pulmonary function (chronic pulmonary disease due to emphysema, associated bronchitis, bronchiectasis, and cardiac disease) complications are more likely to occur. The development of complications in those patients with no significant cardiac or pulmonary disease was low. The relationship of associated bacteremia to complications was a striking one. We found 12 instances in which the blood cultures were positive on admission. In 11 of these some form of complication developed. The literature confirms our findings that bacteremia is just as prevalent today as it was before the introduction of specific therapeutic agents.[6] In addition to the complications studied, there were 3 deaths. All 3 patients had had bacteremia on admission. We were unable to relate the type of pneumonia to the subsequent development of complications. In our series of cases, chronic alcoholism did not seem to affect the occurrence of complications.

Although other diseases such as carcinoma or pulmonary tuberculosis are not a complication of pneumonia *per se*, we feel that they should be suspected and looked for in all cases where progress is not satisfactory. We have made it a practice in the management of pneumonia in this hospital to follow such cases with bronchoscopy so that the tracheobronchial tree can be directly visualized and suitable biopsy material can be obtained. Only in this fashion can early pulmonary neoplasm be diagnosed. Tuberculosis should be sought by appropriate methods.

Conclusions

We feel that a satisfactory response of bacterial pneumonia to antibiotic therapy can be defined. In spite of modern therapeutic agents, the complications of pneumonia have not been significantly reduced.[1,3,5] It is felt that the reasons for the present complications can be related to the lack of resistance in the host. Therefore, it seems likely that any further improvement in therapy will come about through reinforcement of the natural resources of the pa-

tient and the avoidance of delay in treatment.

(R. B.) Veterans Administration Hospital.

(The authors are deeply indebted to Drs. Donald M. Willson, George C. Owen, Karl A. Liefert, and Mark W. Garry, Veterans Administration Hospital, Wood, for their assistance in setting up the study, evaluating the results, and proofreading the manuscript.)

REFERENCES

1. Thompson, R. T., and others: Pneumococcus types, mortality, bacteremia, and purulent complications in primary pneumococcic pneumonia at the Cincinnati General Hospital, J. Lab & Clin. Med. 34:1757–1758 (Dec.) 1949.
2. Dowling, H. F., and others: The treatment of pneumococcic pneumonia with aureomycin, J. Lab. & Clin. Med. 35;215–219 (Feb.) 1950.
3. Kirby, W. M. M., and others: Comparison of aureomycin and chloramphenicol in the treatment of bacterial pneumonia, J.A.M.A. 147:110–115 (Sept. 8) 1951.
4. Jackson, G. G., and others: Terramycin therapy of pneumonia: clinical and bacteriologic studies in 91 cases, Ann. Int. Med. 35:1175–1202 (Dec.) 1951.
5. Israel, H. L., Mitterling, R. C., and Flippin, H. F.: Pneumonia at the Philadelphia General Hospital, 1936–1946, New England J. Med. 238:205–212 (Feb. 12) 1948.
6. Anderson, T.: Pneumonia–a survey–past and present, Edin. Med. J. 55:705–720 (Dec.) 1948.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 36 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WHLA	West Salem	Saturday	10:30 a.m.

Proceedings of the Milwaukee Academy of Medicine, March 17, 1953

Therapy Not to Employ in the Treatment of Peptic Ulcer

By H. MARVIN POLLARD, M. D.*
Ann Arbor, Michigan

IT IS not the purpose of this paper to exclude completely certain items of medical ulcer therapy but rather to evaluate their role more thoroughly if they are to be employed in the treatment of a patient suffering from gastric or duodenal ulcer.

The first item which I want to discuss is the operation of dorsal splanchnicectomy, now accepted as one means of assisting in the control of primary hypertension. We recently took occasion to evaluate the results of this operation when it had been used in a patient suffering from both hypertension and duodenal ulcer. This study was prompted by the fact that since the splanchnic nerves carry the pain sensations from the gastrointestinal tract, interruption of these fibers obviously deprives the stomach and duodenum of its normal pain sensations and may also cause alterations in function. In a group of 1,498 patients in our institution who underwent splanchnicectomy for hypertension during an 11 year period, there were 13 cases of peptic ulcer. Two of these patients subsequently died of a massive hemorrhage. A postmortem examination in each case revealed the presence of a large active duodenal ulcer. In neither case had there been any symptomatology suggesting an ulcer before the hemorrhage. Three other cases required laparotomy, 2 for hemorrhage and 1 for perforation. In each case the discomfort noted was mild and atypical. It seems clear to us that after splanchnicectomy in a patient who also has a duodenal ulcer the normal epigastric pain sensations are either abolished or greatly reduced, so that the ulcer is permitted to advance to dangerous proportions without giving the usual warning pains. At present we are reluctant to advise splanchnicectomy on a patient with a known duodenal or gastric ulcer.**

Physicians confronted with the medical management of patients with peptic ulcer are now utilizing the antisecretory and anticholinergic drugs to an extensive degree. There is no doubt that these drugs are pharmacologically active, particularly on gastric motility, and less so on gastric secretion. The chief concern over their use is to realize that they should not be employed alone or as the only treatment for the ulcer. All the other measures, such as rest, diet, alkalies, and sedation, should be used concomitantly. These drugs continue to have side effects capable of increasing bladder atony in patients with prostatic obstruction. If a patient has a pyloric obstruction, use of these drugs may increase it. During the time of their use an increased tolerance to the drugs may also develop and make constant dosage ineffective. Instances have also been observed of recurrence of the ulcer while on these drugs, as well as increase in the size of the ulcer, onset of hemorrhage, etc. This merely means that although the drug may be helpful, it by no means should be used alone to do the job of healing an ulcer.

The third caution which I wish to express here refers to the use of ACTH and cortisone. There are multiple situations in which these drugs are being employed daily without regard to the presence or absence of gastric or duodenal ulcer. Experimental evidence indicates that after the administration of ACTH there is an immediate increase of uropepsin. There is also a parallel rise of gastric juice pepsin. It is already known that ulcer patients have high levels of uropepsin excretion; in one instance a control level of

* From the Department of Internal Medicine, University of Michigan Hospital, Ann Arbor, Michigan.

** Prefrontal lobotomy also has been followed by perforation of an old duodenal ulcer.—Ed.

6,000 units rose to 16,000 units after the administration of ACTH. Other studies have shown that both ACTH and cortisone interfere with wound healing, which, of course, is an undesirable feature in the presence of an active peptic ulcer. The concentration of acid in the stomach juice may increase within one to two weeks by as much as 200 to 300 per cent. The above facts no doubt help to explain why we not infrequently see the flaring-up of an old ulcer, the onset of hemorrhage from the stomach, or even perforation. We should, therefore, use great caution in a patient receiving ACTH or cortisone, or at least determine first whether he has a duodenal or gastric ulcer, active or inactive.

Finally, we have been uniformly discouraged in our results with patients suffering from gastric or duodenal ulcer where hormones such as enterogastrone or urogastrone have been employed for treatment. There has been little alteration in the recurrence rate with this kind of hormone therapy.

ROCKY MOUNTAIN CANCER CONFERENCE TO BE HELD JULY 8 AND 9

The seventh annual Rocky Mountain Cancer Conference will be held in Denver on July 8 and 9. As in previous years there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their ladies. There is no registration fee for this Conference.

Further information may be obtained by addressing Mr. H. T. Sethman, executive secretary, Colorado State Medical Society, 835 Republic Building, Denver, Colorado.

TB SYMPOSIUM FOR GP'S IN SARANAC LAKE THIS SUMMER

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, New York, from July 13 through July 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for members of the American Academy of General Practice and $50 for non-members. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

These symposia are the result of many requests from general practitioners for a postgraduate course on pulmonary tuberculosis designed for them and presented over a period short enough so that they might readily attend. The 1953 symposium has been planned to meet those needs and to cover all important aspects of pulmonary tuberculosis from the general practitioner's point of view.

Many of the sessions are informal panel discussions with ample opportunities for questions from the audience.

The symposium will be held in various sanatoria and laboratories in the Saranac Lake area. Morning sessions will be from 8:30 to 12:30 and afternoon sessions from 2:00 to 3:30 (Monday, Wednesday, and Thursday). There will be elective sessions on Tuesday and Friday afternoons. Physicians desiring to make patient rounds will have that opportunity each afternoon at 4:00. On Monday, July 13, there will be a dinner for physicians attending the course, their families, and the faculty.

The speakers and panel members at the tuberculosis symposium will include physicians, surgeons, and scientists from Saranac Lake and surrounding areas.

Complete information concerning this program can be obtained by writing Richard P. Bellaire, M. D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and
J. F. KUZMA, M. D., Marquette University School of Medicine, Milwaukee

PRESENTATION OF CASE*

Elton Mendeloff (Senior Medical Student): The patient was a 63 year old male laborer in a wood factory who was admitted on Nov. 17, 1951, with complaints of abdominal pain and jaundice. Two months before his admission generalized sharp abdominal pain, accompanied by progressive jaundice, light stools, and dark urine, had developed. For several weeks the patient had noted anorexia, early satiety, and some nausea. The week before admission he had had an episode of hematemesis of dark red blood. He also gave a history of recent constipation, pyrosis, and occasional black stools after eating prunes. He had lost 28 pounds in the previous year and 16 pounds in the past month. He had been hospitalized in a private hospital five weeks before admission, where a diagnosis of carcinoma of the liver with metastases had been made. There was no evidence of pruritus, change in stool caliber, previous icterus, food intolerances, or aggravation of the pain by anything in particular.

His past history included the usual childhood diseases, smallpox, and left-sided pneumonia with pleurisy in 1918. His father and mother had both died of pleurisy and one brother had died of carcinoma of the stomach. Systemic review was essentially negative except for occasional burning of the tongue, a slightly productive cough for one month, an occasional sharp left chest pain, and varicosities.

Physical examination revealed an emaciated white male with evidence of marked weight loss. The temperature was normal. There was marked icterus of the skin and scleras, with pallor of the mucous membranes. The trachea was slightly deviated to the right. The lungs were hyperresonant to percussion, and the heart tones were distant. The pulse was regular at 96 and the blood pressure was 110/80. The liver was palpable two fingerbreadths below the right costal margin in the anterior axillary line and was non-tender. There was a suggestion of an ill-defined hard mass with several small subcutaneous nodules in the epigastrium. Bilateral inguinal nodes were palpable. The genitalia were atrophic. There was slight clubbing of the fingers. Rectal examination was negative. The initial impression was gastric carcinoma with biliary obstruction and metastases to the lungs and liver.

On admission the urine was amber, cloudy, and acid; specific gravity 1.014; and 10 to 12 white blood cells per high power field. A few epithelial cells and bacteria were also noticed. One plus bile was present. The blood serology was negative. The white blood cell count was 15,000, and the differential count showed 71 segmented, 10 stabs, 10 lymphocytes, 4 monocytes, 2 juvenile cells, and 3 myeloblasts. There were 9 normoblasts per 100 white blood cells. The red blood cell count was 3,090,000 with 11 Gm. of hemoglobin. The sedimentation rate (Westergren) was 25. Moderate polychromasia and target cells were present. The inorganic phosphorus was 5.7 mg. per cent, alkaline phosphate 66.3 units, total proteins 5.98 Gm. per cent with an albumin of 4.28 and a globulin of 1.70. The total cholesterol was 317 mg. per cent with a free cholesterol of 276 mg. per cent. The 1 minute van den Bergh test was 14.8 mg. per cent and the 25 minute 26.3 mg. per cent. The thymol turbidity was 6.9 units, and the zinc sulfate 9.0 units. The prothrombin was 21 seconds or 33.7 per cent of normal.

The patient was placed at bed rest on a high protein, high carbohydrate, low fat diet. On the third hospital day his jaundice deepened, and he complained of nausea and anorexia. His temperature rose to 100 F., he became restless and incontinent of urine. The next day he was placed on Wangensteen suction and several liters of coffee-ground fluid were aspirated. By the following day he was lethargic and mentally confused. On the sixth hospital day he became comatose and died.

William Woods (Senior Medical Student): Laboratory interpretation: the chest plate showed minimal emphysema of the lower

* From the Departments of Pathology, Veterans Administration Hospital, Wood, and Marquette University School of Medicine, Milwaukee.

lung fields but no evidence of any metastatic involvement. The heart and great vessels were within normal limits. Even on the chest film there was great dilatation of the stomach with a fluid level and air above it. On the anteroposterior film of the gastrointestinal series, a greatly dilated stomach with a complete obstruction at the pylorus was seen. No filling defect was visualized, although barium did not fill well because of the excessive accumulation of fluid. The right anterior oblique film again showed complete obstruction at the pylorus and gastrectasis.

In a consideration of the laboratory findings, we note that this man had a neutrophilia and immature cells in his peripheral blood, including blast forms. Whenever we see blast forms in the peripheral stream, we must decide whether this is a leukemic picture or whether this may be a so-called leukemoid reaction. If this were a leukemia, I believe we would find a more pronounced immaturity of the white cell series. Here we have a neutrophilia with a high percentage of adult forms and a fairly normal stab percentage. Also, the anemia would be more severe, and we would expect a thrombocytopenia. This, then, may be a leukemoid reaction. Similar reactions are also seen in malignancy, especially when there are metastases to bone marrow. Here we have 9 normoblasts per 100 white blood cells, and they should not be seen in the peripheral blood at all on a normal smear. If this is an involvement of bone marrow by metastases, so-called myelophthisic anemia, one could find normoblasts in the peripheral blood even with only a moderate anemia. We would also see the appearance of immature white cells, including myelocytes and myeloblasts, and polychromasia, target cells, and reticulocytes, such as we see here. Although repeated determinations would be necessary to definitely rule in one or the other of these conditions, I feel that it is fairly safe to say that this most likely could be due to bone marrow invasion.

In this case the differential diagnosis of jaundice on the basis of laboratory findings alone is somewhat incomplete but can still be discussed with some degree of accuracy. The patient's early death prevented a complete study of liver function, but what we have here is sufficient for some postulation. The presence of bile in the urine and the increased direct-acting van den Bergh test would tend to rule out a hemolytic type of jaundice. The alkaline phosphatase was 66.3 units. This is greatly elevated, and it has been said that an alkaline phosphatase over 10 units would tend to indicate an obstructive type of jaundice, whereas alkaline phosphatase under 10 would go along more with hepatocellular type of damage. This, of course, is greatly elevated, and it would be a strong argument in favor of the obstructive type of jaundice. The total proteins here were near normal. The albumin was not decreased nor was the globulin increased as we would expect in a hepatocellular type of jaundice. That again would be compatible with an obstructive type of jaundice. Total cholesterol of 317 mg. per cent is elevated. This again tends to go along with an obstructive jaundice, but here we have equivocal findings, in that the ratio of free cholesterol is greatly increased.

One of the first things we might see in hepatocellular type of damage is an increase in the ratio of free to total cholesterol. That is the finding here. However, in hepatocellular jaundice we would expect to see a great decrease in cholesterol esters, since the liver synthesizes the cholesterol. Here, although we have the reduction of cholesterol esters as a terminal event, I do not believe they are low enough to say that this is an indication of great hepatic damage. It may indicate that some hepatic damage is present. In again considering the elevation in the 1 minute and 25 minute van den Bergh tests, we cannot say that this is an obstructive or hepatocellular type of jaundice. However, this great elevation of the 25 minute van den Bergh and the rather high ratio of direct-acting bilirubin to the total bilirubin would tend to go along with an obstructive type, although the finding itself is certainly not too significant. The prothrombin time of 33.7 per cent gives us no information, since it is possible to have a reduced prothrombin time in hepatic damage. We can also have a reduced prothrombin time in an obstructive type of jaundice, since the lack of bile salts in the duodenum prevents the absorption of vitamin K, which is essential to the synthesis of prothrombin. If we had had a parenteral injection of vitamin K, a good increase (over 20 per cent) in the prothrombin would tend to suggest an obstructive type of jaundice. However, the patient died before that was accomplished. The zinc sulfate and thymol turbidity determinations

showed minimal change. The zinc sulfate was 9, well within the normal limits (2–12) for this hospital. The thymol turbidity was slightly positive. On the basis of the minimal changes in the liver function tests (zinc sulfate and thymol turbidity), the greatly increased alkaline phosphatase and inorganic phosphorus, the lack of change of the albumin-globulin ratio, the relatively normal serum proteins, the elevated total cholesterol, and the increased ratio of direct-acting bilirubin to total bilirubin, I feel that the laboratory findings are compatible with an obstructive type of jaundice, perhaps accompanied by some hepatic damage which may be on the basis of long-standing obstruction.

Norbert Lochowitz (Senior Medical Student): This case resolves itself primarily into a differential diagnosis of a jaundiced patient. There are several important clinical points in the protocol that aid the clinician in the differential diagnosis, and we will consider them in order, and then correlate them with the laboratory findings. Mr. Woods has used the term "obstructive jaundice" and any clinician approaching the problem of jaundice has to bear in mind a classification. The classification he uses is that of McNee, which includes the hemolytic, the hepatocellular, and the obstructive types. Many clinicians place much importance upon the age of the patient. Being confronted with jaundice in a child we would suspect a congenital hemolytic type. During adolescence and adult life, in the second and third decades, we would consider the varied hepatitides. As we approach the fourth decade, we must keep in mind the calculus obstructive type of jaundice, and in the elderly age group, a consideration of neoplastic type of jaundice is mandatory.

In approaching any case of jaundice, we must always inquire about the patient's habits and occupation. In a patient who is sustained with alcoholic beverages, we should consider Laennec's cirrhosis; in a patient who is in occupational contact with hepatotoxic drugs, a toxic hepatitis; and in a patient who has an occupational contact with rodents, such as a sewerage cleaner and garbage disposal man, a consideration of Weil's disease is necessary. As a wood worker, this man was not in contact with any such agents. Sex also deserves considerable attention, because obstructive neoplastic disease is four times more common in men than in women.

The patient complained of abdominal pain and jaundice. Contrary to classical teaching, about 75 per cent of patients with jaundice due to neoplastic disease have pain. This patient's pain was a sharp type of abdominal pain. Sharp abdominal pain leads one to think of a venous thrombosis, which is very common in any type of jaundiced patient, particularly cirrhotics.

The duration of jaundice is important. When a patient has jaundice of a progressive nature over a period of at least one month or more, a diagnosis of neoplastic disease must be seriously considered. The color of jaundice is also given considerable importance by many clinicians. A lemon-yellow color is sometimes considered typical of the hemolytic type of jaundice, and that of butter-yellow is sometimes considered in hepatitis. In the obstructive type of jaundice we see the very dark or yellowish-greenish-black type of jaundice. No mention is made of the color of jaundice this patient had, but the progression indicates a deepening dark color of jaundice.

The observation of the stool in any patient with jaundice is extremely important. If the patient has clay-colored stools for a few days followed by normal brown stools, one usually considers a hepatitis due to the obstructive edema, which has subsided. With the intermittent acholic type of stool, one considers the calculus type of jaundice, but with a persistent, unrelenting type of acholic stool, we would have to consider primarily a neoplastic obstruction. Dark urine makes one suspect that bile is present in the urine. Bile in the urine rules out hemolytic jaundice.

The patient had several gastrointestinal disturbances, such as anorexia and early satiety. Gastrointestinal disturbances are sometimes indicative of the pre-icteric phase of infectious hepatitis. Anorexia is commonly seen as the first sign of any cirrhotic. Anorexia is also seen in the neoplastic diseases. When you consider a jaundiced patient with recent onset of constipation, it makes you suspect that a neoplasm of the gastrointestinal tract is probably present with metastases to the liver. That point has to be ruled out. Two weeks before, the patient had had a hematemesis of dark red blood. Hematemesis in a patient with jaundice lends itself to several primary considerations; the first one (an acute emergency) is rupture of esophageal varices due to portal hypertension; the

second is hematemesis due to an ulceration of the gastrointestinal tract or to hypoprothrombinemia. Melena, in this case, would be an important finding. The man has an extreme weight loss. We see weight loss in hepatitis, and we see weight loss in cirrhosis, but neither is as spectacular as the weight loss seen in a neoplastic disease. Of all the neoplastic diseases with extreme weight loss, carcinoma of the pancreas is the most common.

There are several points in the negative findings. There is no pruritus, but that has no diagnostic significance. Of course, there is no pruritus in hemolytic jaundice, but usually you have a mild pruritus in hepatitis and very severe pruritus in the neoplastic type of disease. However, clinicians do not pay too much attention to that in the differential diagnosis. In his past history I find nothing of any significance, unless you are of the school that believes carcinoma is hereditary. However, in a systemic review, we find an interesting point. The patient had burning of the tongue. If you see that in a jaundiced patient, you think primarily of a vitamin deficiency or nutritional deficiency and nothing is more common in a cirrhotic individual than a nutritional deficiency. Outside of that I find nothing of any importance.

In the physical examination the deviation of the trachea had no significance, as borne out by x-ray. He had the emphysematous changes that were seen. He had a rigidity of the musculature that is a little bit disturbing to me. I do not know whether the rigidity is due to his uncooperative examination, or if it is due to peritoneal irritation. At least the patient does not have ascites, and that is an important point. The liver was palpable—I think the two fingerbreadths are significant in this case. A palpable liver is probably due either to metastases or to bile stasis. I do not think the description is quite adequate. I would like to know if the liver was hard. A nodular, stony liver is sometimes seen in primary hepatoma. There was a suggestion of a hard, ill-defined epigastric mass. This lends itself to several considerations. In the epigastric areas neoplasms can cause jaundice by infringing upon the extrahepatic structures in that area. Particularly in the area of the ampulla, an area .5 cm. in diameter, several neoplasms can arise from the ampulla itself, from the terminal end of the common duct, from the glandular tissue of the pancreas, or from the mucosa of the duodenum. I doubt that a clinician could possibly differentiate the type of mass in that area. Of course, we have to consider that the mass might be arising from the stomach. It might be a portion of the liver. It might be a primary hepatoma. It might be carcinoma of the pancreas or it might even be retroperitoneal lymphoma or it might be any type of metastasis from a primary site anywhere in the body. There is a note here that the patient had several subcutaneous nodules. These of course might be only benign lipomata, but in this case I think we have to be very careful. Probably we should assume that these nodules are metastases. Bilateral inguinal nodes are palpable in a great many people, and if we had confirmatory evidence of cervical nodes, particularly the Virchow's node, which is seen primarily in carcinoma of the stomach or in any neoplasm that can erode into the ductal system, we might attach more significance to it. The genitalia were atrophic, and the left testicle was softened. I have been impressed in this hospital by the fact that any time you see a testicular atrophy or softening in a jaundiced person you must consider cirrhosis. If it is confirmed by any other things such as palmar erythema, gynecomastia, loss of pectoral hair, and varicosities, which the man had, and hemorrhoids, you probably conclude that the man definitely has cirrhosis. I bring this point in because people who have primary hepatoma are usually people who have an underlying cirrhosis. The rectal examination was negative. That is always an important point. We would like to know, of course, whether the man had a proctoscopic examination. If the man had had a barium enema it might have revealed a carcinoma higher in the colon. But the fact that the examining physician did not feel anything with his finger might indicate that he did not feel the rectal shelf commonly found in peritoneal carcinomatosis. The man's course was, indeed, a very rapid one. A man who dies after an illness of 2 months and 5 days, in a confused, listless, anorexic, and comatose condition, leads one to the clinical impression that he might have died of hepatic failure. The fact that the man had white blood cells and a few epithelial cells in the urine leads one to think that possibly the man died of hepatorenal syndrome. I think the man did die of a carcinomatous condition. I think also

that the laboratory bears out the conclusion that this was of an obstructive nature.

Now we come to the possibilities in this case. We have an elderly, white male with progressive jaundice, who died in a short period of time with a mass in his epigastrium causing extrahepatic and pyloric obstruction. We have to think of all the possibilities that could cause this condition. I have considered first carcinoma of the pancreas. Secondly, I would consider carcinoma of the stomach. Thirdly, I am going to consider primary carcinoma of the liver. And of course, lastly, the patient may have had a primary malignancy somewhere in the body with metastatic involvement of the liver or ducts.

Clinical diagnosis: biliary cirrhosis due to obstruction by extrahepatic carcinoma.

Dr. Bertram Dessel: Why did he die?

Norbert Lochowitz: That is an interesting point. Do you have to give a cause of death when a patient dies of neoplasm? If I had to stick my neck out, I'd say that he probably died of uremia, but I don't see an elevated nonprotein nitrogen.

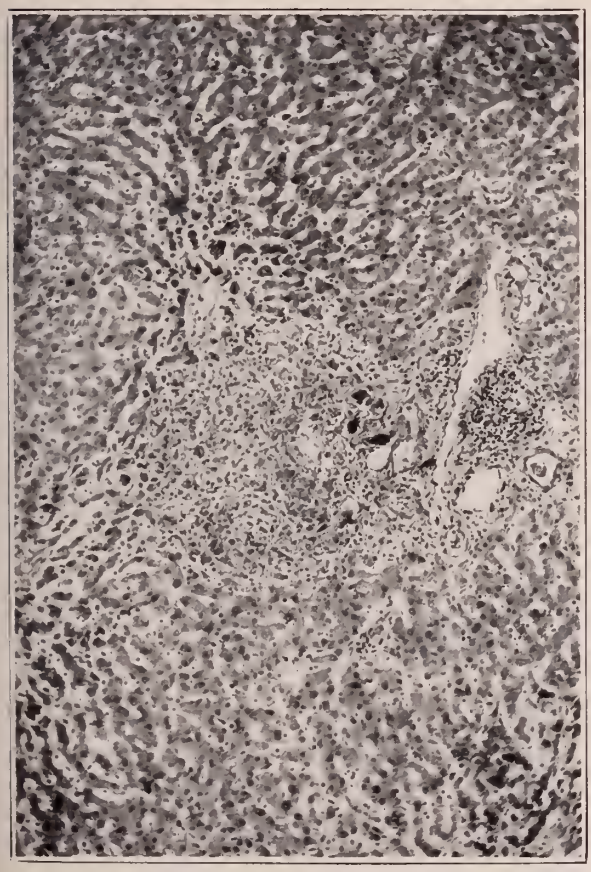


Fig. 1—Photomicrograph of liver: the portal area shows periductal inflammation and fibrosis. Bile ducts are dilated and filled with bile plugs. (130 x)

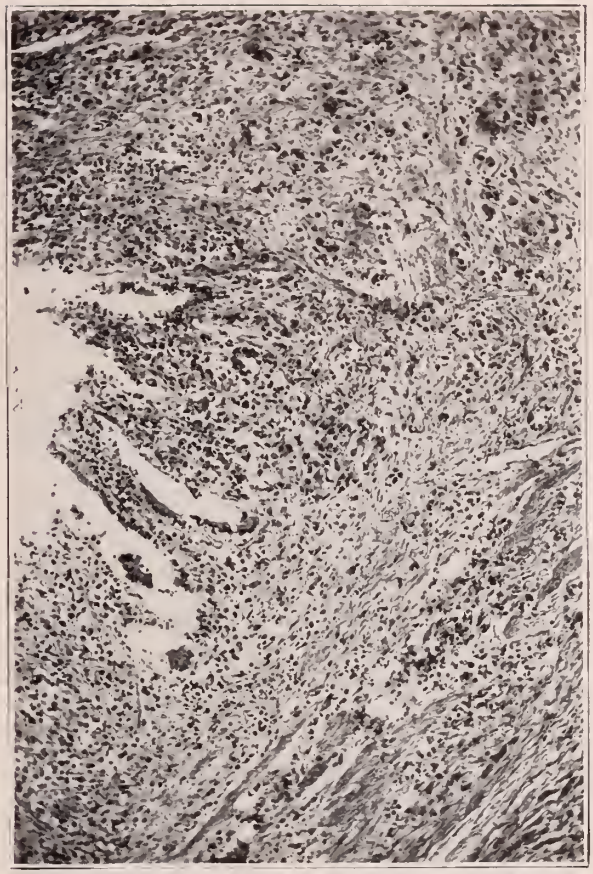


Fig. 2—Photomicrograph: carcinoma of bile duct. (225 x)

Dr. O. Edward Ogilvie: The body is that of a well developed, emaciated, 63 year old white male who measured 68 inches in length and weighed 115 pounds. The skin was deeply jaundiced. On internal examination, all organs exhibited greenish discoloration. The lungs were partially collapsed and congested. The heart weighed 300 Gm. and was soft and flabby. The abdomen contained about 200 cc. of a clear yellowish-green serous fluid. The liver weighed 1,690 Gm. The surface was smooth and grayish green in color. The cut surface was yellowish tan, finely mottled with green. The bile ducts were dilated and filled with dark green bile. On microscopic examination biliary stasis and periductal inflammatory changes were found. (Fig. 1) The gallbladder was slightly enlarged, and the wall was thickened. The lumen contained about 20 milliliters of thick, viscid, dark green bile and a large yellowish-green calculus. The common duct was a hard, cord-like structure that measured 8 mm. in

diameter and on cut section was found to consist of dense grayish-yellow neoplastic tissue. The lumen was greatly narrowed and completely occluded at one point. Microscopic sections showed a diffuse, infiltrating carcinoma. (Figs. 2 and 3) The cystic duct was also thickened by tumor tissue. The spleen showed only congestion. The kidneys showed cloudy swelling. The prostate was enlarged by benign hypertrophy. The stomach was greatly distended with gas and 500 milliliters of grayish-red fluid. The mucosa was deeply

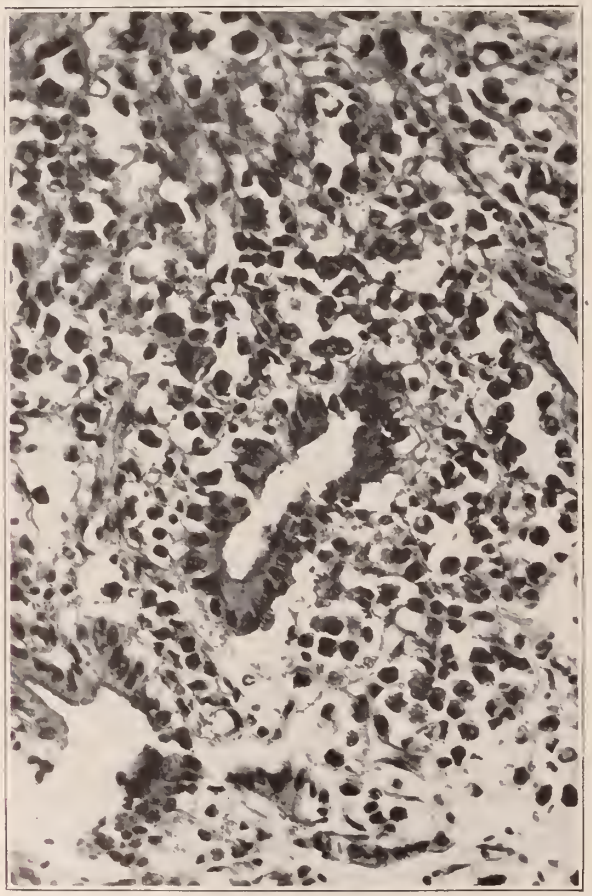


Fig. 3—Photomicrograph: carcinoma of bile duct. Infiltration of mucosa by tumor cells. (325 x)

congested and hemorrhagic. The pylorus, although hypertrophic, was not obstructed. No erosions, ulcers, or neoplasms were observed in the gastrointestinal tract. The second part of the duodenum was continuous exteriorly with a mass in the porta hepatis which was found to be a partially organized abscess. The pancreas was firm and yellowish tan in color. It appeared uninvolved by tumor tissue, but on microscopic examination metastatic tumor was found. The periaortic lymph nodes in the region of the pancreas were enlarged and hard. On cut section they showed neoplastic involvement. The bone marrow, on microscopic examination, was found to be infiltrated with tumor cells. In summary, we found an emaciated, jaundiced white male, with biliary cirrhosis and carcinoma of the extrahepatic biliary ducts, with metastases to the periaortic lymph nodes, liver, and pancreas. The cause of death was carcinoma of bile ducts with metastases.

Anatomical Diagnoses: 1. Scirrhous adenocarcinoma of bile duct with metastases. 2. Biliary cirrhosis of liver.

John Chamberlain (Senior Medical Student): I think we all agree that the diagnosis by Mr. Lochowitz of extrahepatic biliary duct obstruction was the correct one. As far as a definitive diagnosis is concerned, it is not too important, in that once we recognize that it is a case of extrahepatic biliary obstruction, the treatment is immediate surgical intervention if at all feasible. Of course, in this case, the patient's status was terminal and no more than symptomatic treatment could be carried out.

It is interesting to note that the incidence of extrahepatic duct malignancy varies widely with different authors. Bockus states that the incidence is very low, but feels that it is actually not as rare as we would think from the literature. He feels that many of the strictures which are found with large tumors in the area might very well be carcinoma of the extrahepatic duct. Up to 1929 only 112 cases of this entity were found in the literature. In a 1922 report of 1,000 consecutive operations on the ductal system at the Mayo Clinic, 34 carcinomas of the extrahepatic system were found. Renshaw says that if they are one fourth as common as carcinoma of the gallbladder, one cannot say they are common. Strangely enough, there is a similarity of opinion in the findings of Shapiro and Litmandahl, who found that in cases of carcinoma of this area, the microscopic diagnosis pointed to 62 cases of the duct, 55 of the gallbladder, and 41 of the head of the pancreas. So if we were to follow their series, extrahepatic duct carcinoma would probably be first. The average age incidence is 50 to 70, as in most cases of carcinoma of the gastrointestinal tract. The sex incidence is exactly opposite that of gallbladder carcinomas. In primary carcinoma of the gallbladder, the cases are 4 to 1 in favor of females, whereas extrahepatic duct

carcinomas predominate in males. The etiology of extrahepatic carcinoma is uncertain. Since stones are found in about 80 per cent of carcinomas of the gallbladder, they appear to be a definite etiologic factor. Stones are found in approximately 9 per cent of the general population. Since we find stones in 30 per cent of cases of extrahepatic duct carcinoma, there may be an etiologic factor involved. Other factors are antecedent adenomas, biliary necrosis, ulcerations, hyperconcentration of bile, and extension of duodenitis.

Pathologically, the most common site of carcinoma is the common duct; second in frequency is the junction of the cystic duct, common duct, and common hepatic duct; and, thirdly, the hepatic duct alone. The clinical findings of each case are related to the site. If we have carcinoma of the cystic duct alone, we are not going to find jaundice unless it infiltrates into the common duct. Metastases of carcinoma of the extrahepatic biliary system are found in 25 per cent of the cases because in many instances the patient dies of primary obstructive jaundice before there is a chance of metastases. In the carcinomas that do metastasize, the most common sites are the liver, regional nodes, lungs, and pancreas, as found in this case. I noted no reports in the literature of involvement of bone marrow, as was found in this case. I think the important thing to bring away from this discussion is the fact that once we have differentiated between the hepatocellular and obstructive jaundice, the definitive diagnosis is not necessary. If we find that we have an obstructive jaundice, the surgical approach, if feasible, is the one that we should follow. The majority of patients with this kind of jaundice live about six months after the first onset of the disease.

MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have graduated from medical school within the past ten years and are residing in the state of Wisconsin or are in the Armed Forces at the time the essay is submitted. Physicians who graduated from medical school more than ten years ago may submit essays if deduction of their period of service in the Armed Forces will bring them within the above-mentioned ten year period after graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial Contest for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, though not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be double spaced and submitted in triplicate to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Questions and Answers Suggested by Recent Investigations in Drug Therapy

What conditions should be considered contraindications to the use of emetine in amebiasis? In a recent study of the toxic effects of emetine in 111 patients with various types of amebiasis, reported by Sodeman,[1] there were 8 patients with advanced heart disease before the therapy was begun. Despite the fact that significant electrocardiographic changes associated with this therapy were recognized only once, and that Sodeman did not look upon the usual moderate T-wave changes seen during emetine therapy as in themselves indicating cessation of the use of the drug, it should probably be accepted that the drug is contraindicated in patients with cardiac disease unless the condition for which it is employed threatens life more than the heart disease itself. Even then, it should be used only if no other therapeutic agent is satisfactory. Emetine should also be used very cautiously in individuals of advanced age, and probably not at all in pregnancy.

What consideration should be borne in mind in selecting cation exchange resins in treating congestive failure? It has been pointed out by Greenman[2] that the effects of hydrogen and ammonium cycle resins are not limited to deviation of sodium to stools. They both produce acidosis, which can be looked upon as desirable in the control of edema in patients who do not have impaired renal function. But in patients with far advanced renal failure, frank acidosis and overbreathing may accompany their use. Accentuation of acidosis when it is already present as a consequence of renal insufficiency undoubtedly exerts further stimulus to urinary sodium and water losses. Such patients should probably be treated with smaller amounts of resin or with nonacidifying resins. Whether or not increasing the loss of potassium in the stools and the production of negative potassium balance is desirable must be decided in each individual case. If the patient is starving or is taking mercurial diuretics or ACTH or cortisone, his potassium requirements will be increased. But of course if he has stored potassium excessively, the potassium loss induced by these resins would be beneficial. Sodium cycle resin is believed to have no general usefulness, though it may be extremely helpful in particular cases. Accumulation of potassium is accompanied by excess of sodium in most renal disease states. Thus far only limited experience has been had with calcium cycle resins, but it is thought that gram for gram they should prove less effective in inducing diuresis, since they do not have acidifying effects. However, this fact may be useful in patients with renal failure if it serves to increase sodium and potassium losses in the stools.—HARRY BECKMAN, M. D.

REFERENCES

1. Sodeman, W. A.: Emetine therapy and heart disease, Am. Heart J. 43:582–585 (April) 1952.
2. Greenman, L., Peters, J. H., Mateer, F. M., and Danowski, T.S.: Probable clinical utility of cation exchange resins, J. Clin. Investigation, 30:1027–1031 (Sept.) 1951.

PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected re-registration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana, write immediately to the office of the Director of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect re-registration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

Civil Defense—Progress in Medical Supplies

As It Looks to Your State Board of Health

THE matter of the obtainment, storage, and quick distribution of medical supplies for atomic warfare casualties is a serious and difficult problem for authorities concerned with this responsibility. The number of casualties and the medical needs resulting from a single A-bomb would tax the resources of any city and state even with regional federal assistance. When this situation is multiplied by simultaneous bombings throughout the nation, the problem becomes even more difficult and complex.

While adequate for normal disaster and civilian needs, the usual supply house inventories are grossly inadequate for atomic warfare; many key items would be in critical shortage before the last bombs of the initial nationwide onslaught had fallen. In recognition of this, authorities in large cities and on state and federal levels have cooperatively undertaken the purchase and stockpiling of conservative amounts of disaster supplies. The extent, nature, and responsibility of each authority has been well delineated.

At the federal level, regional defense supply depots have been established. Here, the type of supplies being stocked are primarily those needed to replenish hospital needs, to sustain whole-blood procurement programs, and to assist with plasma and plasma substitute requirements. Federal supplies, in relation to national priorities, will be made available to delivery points designated by the state.

In Wisconsin, state authorities are concerned with stockpiling first-aid units for 100 mobile medical teams. In training and equipment, these teams are intended to provide only life-saving first-aid care and to stabilize patients for movement to definitive care facilities. Their supplies, listed in Table 4.36, Health Service and Special Weapons Manual AG–11–1, weigh about 600 pounds per team. Also included are certain other items such as morphine, antibiotics, blankets, litter-cots, dried plasma, basins, and lanterns.

Cities subject to bombing are expected to stockpile a substantial portion of their total needs, particularly supplies for initial use. It is not anticipated that either federal or state supplies can be made available in time for immediate use or in quantity for total casualty care. In Wisconsin, as in most other states, hospitals have also agreed to maintain high inventories in anticipation of casualty needs and to participate in an emergency whole-blood procurement program.

The federal depot from which Wisconsin will be allocated materiel is located in northern Indiana at an estimated distance of 6 to 10 delivery hours. More than three million dollars' worth of medical supplies are currently in stock at this depot. When completed, the stockpile will have substantial amounts of nearly 100 different medical and hospital care items, covering needs for instruments, dressings, splints, antibiotics, morphine, plasma and plasma substitutes, typing sera and whole-blood sets, etc.

Table 4.36 supplies purchased for state mobile teams have been arriving at the Wisconsin National Guard depot at Camp Douglas for more than six months. At this time about 50 per cent of these have been received. When delivery is completed, the materiel will be packaged into 100 duplicate units and supplemented with litters, litter-cots, plasma, and some additional items. Currently there are over 2,500 litters in storage. Litter-cot deliveries are scheduled to begin in June. Dried plasma with recipient sets has been arriving for over three months and will continue until a maximum of nearly 100 units per team is reached. Arrangements have been made for the post-disaster purchase of 24,000 blankets. It is hoped that eventually some pre-disaster blanket purchases can be made to meet initial demands, pending emergency procurement of total remaining numbers.

In summary it can be said that to date a considerable portion of the federal and state medical and hospital supplies have been secured or delivered. However, to complete state needs, some key items remain to be purchased and safely stored. In addition, certain items must be secured and integrated in civil defense plans for an emergency state-wide whole-blood program. The total blood needs for Wisconsin casualties are estimated to be from 60,000 to 90,000 units of whole blood and a like amount of substitutes.—A. L. VAN DUSER, M. D.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

New Advertising Program

A totally new advertising program for Blue Shield and Blue Cross was initiated during the last week of May. This program will run from May through December and will include all of the daily newspapers, a selected group of weekly newspapers, and, for the first time, a number of primary radio stations. In addition, special advertisements are being placed in labor newspapers, the Catholic Press, and the Wisconsin Bar Journal. The total cost of the advertising program is $63,592.61, which will be shared by Blue Shield and Blue Cross according to their agency agreement.

The newspaper advertisements to run in both daily and weekly papers will utilize a new approach to getting reader attention by the use of actual photographs of surgical and hospital scenes. In addition, through the use of family and mother-and-baby photographs, emphasis will be placed upon the protection offered the entire family. These have been proved to have tremendous reader appeal. In addition, special emphasis is being placed on "hard selling" advertising copy stressing the benefits provided by Blue Shield and Blue Cross.

All daily newspapers will receive advertisements each month. The following weekly newspapers will receive one ad per month. These papers were selected because they provide coverage to areas where there are hospital and medical facilities not adequately covered by daily newspapers.

Algoma Record–Herald
Amery Free Press
Baldwin Bulletin
Berlin Journal
Black River Falls Banner Journal
Boscobel Dial
Burlington Bulletin
Burlington Standard Democrat
Clintonville Tribune–Gazette
Columbus Journal–Republican
Cumberland Advocate
Darlington Lafayette County News
Darlington Republican Journal
Dodgeville Chronicle
Durand Courier Wedge
Edgerton Reporter
Elkhorn Independent
Frederic Leader & Star
Hartford Times Press
Hillsboro Sentry–Enterprise
Hudson Star–Observer
Ladysmith News
Lancaster Grant County Herald
Lancaster Independent
Mauston Chronicle
Mauston Star
Medford Star News
Menomonie Dunn County News
Mondovi Herald News
Neillsville Clark County Press
New London Press–Republican
New Richmond News
Oconto Reporter
Oconto Falls Times Herald
Osceola Sun
Park Falls Herald
Platteville Journal
Plymouth Review
Prairie du Chien Courier
Prairie du Chien County Press
Reedsburg Times Press
Rice Lake Chronotype
Richland Center Democrat
Richland Center Republican Observer
Ripon Commonwealth
Ripon Weekly Press
St. Croix Falls Standard Press
Sparta Monroe County Democrat
Sparta Herald
Spooner Advocate
Stanley Republican
Sturgeon Bay Door County Advocate
Tomah Journal
Tomah Monitor Herald
Tomahawk Leader
Viroqua Broadcaster
Viroqua Vernon County Censor
Waupaca County Post
Waupun Leader–News
Whitehall Times
West Bend Pilot
West Bend News

For its first venture in radio spot announcements, Blue Shield and Blue Cross have established a schedule which calls for three spot announcements a week as follows:

Monday, Wednesday, and Friday

WHBY, Appleton
WATW, Ashland
KFIZ, Fond du Lac
WBAY, Green Bay
WKBH, La Crosse
WKOW, Madison
WOMT, Manitowoc
WMAM, Marinette
WTMJ, Milwaukee
WEMP, Milwaukee
WOSH, Oshkosh
WRJN, Racine
WOBT, Rhinelander
WJMC, Rice Lake
WTCH, Shawano
WHBL, Sheboygan
WSPT, Stevens Point
WDSM, Superior
WOSA, Wausau

Tuesday, Thursday, and Saturday

WEAU, Eau Claire
WCLO, Janesville

Most of the spot announcements will be used between 7 and 7:30 in the morning or 4 to 6 in the evening.

Governor Kohler Speaks on Wisconsin Health*

I HAVE tried to make my weekly executive reports to you on subjects which are of immediate concern to every one of us. Today I would like to talk about the progress which has been made in public health, and I would like to say something about what more we can do to live longer and healthier lives.

Wisconsin is a healthy state. Most communicable diseases are under control. Nowadays parents have the security of knowing that the lives of babies and children are protected against most diseases. Motherhood is safer than ever before.

It wasn't always so. Most of us can remember a time when communicable disease and death raged throughout the state. Forty years ago almost 2,000 lives were lost every year to just three diseases: smallpox, typhoid fever, and diphtheria. I remember from my own boyhood how deadly serious communicable diseases were—especially for babies and children. But now we see an entirely different picture. Last year no one in Wisconsin died of smallpox, just one from typhoid fever, and two from diphtheria! Even tuberculosis deaths have dropped to one tenth of the 1912 fatalities.

It's no exaggeration at all to say that every year many thousands of lives are being saved from communicable diseases here in Wisconsin.

This remarkable achievement is the result of the activities of many individuals and organizations. Credit for it goes to practicing physicians, nurses, schools and communities, to voluntary organizations, and to parents; but over all there can be seen the stimulation and guiding hand of the State Board of Health.

I would like to say a word of appreciation to the seven doctors who are appointed to this board by the Governor. These practicing physicians devote long hours of study to the problems before them week by week as they prepare for the monthly meetings when decisions are made that have a direct bearing on the health of all of us. We're all indebted to them for their splendid example of public service.

The Wisconsin legislature established a State Board of Health back in 1876. Repeated epidemics emphasized the need for centralized public health control, but the board began its work at a time when very little was known about germs. In fact, we could say that back in 1876 they didn't even know that germs cause disease! When Pasteur announced in France that germs did cause disease, scientists throughout the world began a great germ hunt to determine which germ caused each communicable disease. Within a few years, for example, Doctor Koch found the germ which causes tuberculosis.

Those were pioneering years in public health. Then as now, perseverance and actual financial sacrifices by the doctors on the first State Board of Health were required to develop a public health program. Incidentally, it was the fear of Asiatic cholera which prompted the 1885 Legislature to appropriate the first sizable sum of money for public health in Wisconsin. It was in 1904 that the late Dr. C. A. Harper began his splendid 40 years of service as Wisconsin's state health officer, a record of continuous service unequaled in the United States.

From the beginning, the work of the Wisconsin State Board of Health has been preventive—utilizing scientifically accurate health information for the prevention of disease and the postponement of death. Public health work is the stitch in time—the ounce of prevention.

The State Board of Health stimulated vaccination for smallpox so that more people could develop personal resistance to the smallpox germs. It was found that typhoid fever germs were spread by sewage and in drinking water. So, public health engineers were hired to advise families and communities on how to build safe sewage disposal systems, how to drill safe wells, and how to build water purification plants. Public health nurses were hired to show mothers how to protect the family against disease.

Today the Wisconsin State Board of Health has strong programs to maintain the control of communicable diseases. Public health engineers check on sanitation to keep germs under control in water, milk, and swimming places. The State Laboratory of Hygiene has just moved into a fine new building with increased facilities for laboratory tests, which help Wisconsin doctors and health officers in the identification of disease agents and in the protection of the public health.

Our success in the control of communicable diseases has prevented the deaths of many babies and children with the result that more people are living to an older age. Increasing numbers of people are living to be 65 or more years old. Some time or other you have probably visited an old cemetery. You perhaps noticed that many of the tombstones indicated the death of several children in one family. Of course, children and young adults are still dying, especially from accidents, but now more of the deaths are later in life. Just think of this: in 1913 the average age at death was only 40; now in 1953 it's about 63.

Twenty-three years have been added to the life of the average baby born in Wisconsin! That is the

* Presented over the State Radio Network, Sunday, May 3, 1953.

wonderful progress made in public health to which I referred as I began this executive report to you.

Most of this progress has been made by keeping babies and children and mothers alive. Up to now, we haven't done very much about prolonging life for older adults. That is the great opportunity we have right now. If we would just use the knowledge now available, many of us *could* enjoy healthier and longer lives!

I feel very strongly about this and when the facts are brought to your attention I believe that you will feel that way, too.

I'm told communicable diseases are no longer our leading hazard to health. Now our biggest health problem is the kind of disease which is not caused by a germ. We don't catch it from anybody. It's a condition which just develops within a person's body. For almost half of us it will probably be some disease of the heart or arteries. For one in five of us it will probably be cancer. For others it will be diabetes or perhaps not even a disease—it might be an accident.

It takes experts—doctors, engineers, nurses, and laboratory technicians—to maintain control over the communicable diseases. But now they have a new problem to face, a new kind of hazard to health—non-communicable diseases which require *personal* understanding and personal action for control. Each of us must take the first step to protect his own health and life. You and I want to live a longer and healthier life, and each of us must establish his own good health habits. No one can do that for us. For example, we must be careful not to eat too much because excess weight frequently leads to heart disease and sometimes to diabetes. As we get older we must learn to take it easy because the heart and arteries work hard all year every year and they can't take overloading and constant abuse.

Perhaps most important of all, we must be willing to see our family physician if we notice some sign that something is wrong. That gives our doctor a chance to find a heart condition, when he can help us to live with it, or to find cancer early when it is curable, or perhaps a tendency toward diabetes which can be controlled.

By far, the greatest hazard to our health now is diseases of the heart and arteries—they cause 44 per cent of *all* Wisconsin deaths. In spite of the splendid work being done by the State Board of Health, the State Medical Society, and the Wisconsin Heart Association, we still suffer many hundreds of preventable heart deaths in Wisconsin each year.

Much more could and should be done, especially in the field of degenerative diseases. In my capacity as chairman of the Board of Directors of the American Cancer Society I have been made well aware of lives that can be saved from this disease. Every day two Wisconsin women die of cancer of the breast or uterus! At least one of these lives could be saved. All we have to do is use the knowledge now available. Although the State Board of Health, the State Medical Society of Wisconsin, and the Wisconsin Division of the American Cancer Society are very active, I believe that much more should be done by all of us. We can't *afford* to let hundreds of Wisconsin people die of cancer who could have been saved. It is important to encourage people to see their family physician periodically—and especially when they notice some bodily condition which seems wrong. Usually the doctor will find no cancer, and that's reassuring. But if it is a cancer, we give the doctor a chance to find it early when it is small and curable. That's lifesaving.

Other important fields in which the State Board of Health is applying the principles of preventive medicine are mental health among children, dental health, and nutrition. The Division of Dental Education is encouraging Wisconsin communities to fluoridate their public water supplies so that children in these communities will grow up with stronger teeth which are more resistant to decay. Sheboygan, for example, has had fluoridation since 1946. As a result, the younger Sheboygan children have less than half as many cavities as children growing up in communities where fluoride is lacking in the water. Eighty-eight Wisconsin cities and villages are now fluoridating their public water supplies. *No* other state approaches that number.

For many decades the folks living in our larger cities have enjoyed the benefits of well-rounded public health programs. Trained and experienced public health doctors, engineers, and nurses have worked full time to protect the health of these people. In 1947 the Legislature passed an enabling law which would make it possible for rural people to enjoy these same advantages through the establishment of a full-time county health department.

The State Board of Health believes that the most effective public health program is one which is directed and carried out on a local level.

It has been a pleasure to be able to bring to you this executive report of the public health progress we have made in Wisconsin. It is quite proper to take pride in the thousands of lives we are saving from communicable diseases. But now while we continue programs to maintain control of communicable diseases, let us take advantage of new opportunities to prolong life. Wisconsin can come to the fore in the nation in public health if we develop effective programs against non-communicable diseases and home accidents. We *can* look forward to a longer and healthier life if each of us accepts the responsibility for safeguarding his own health.

An Outline to Facilitate the Development of a
SCHOOL VISION SCREENING PROGRAM*

I. PURPOSE:

To detect significant visual defects among school children in the most efficient method possible.

II. ORGANIZATION AND DEVELOPMENT:

A. Planning Committee should include:

1. Public Health Nurse
2. School Personnel
   a. Superintendent or Principal
   b. Teachers
3. Parent Representatives
   a. Health Council
   b. Parent–Teachers Association
4. Medical Personnel
   a. Ophthalmologists (in an advisory capacity)
   b. Health Officer
5. Other interested persons

B. Screening methods:

1. Selection of the vision test to be used. It is emphasized that no specific test is foolproof. Good results depend upon intelligent administration of the test and careful interpretation of the findings.
   a. Snellen test charts equipped with some means of standard illumination (time-tried means of testing visual acuity for distance).
   b. Acceptable mechanical devices for screening purposes may be used by adequately trained personnel. The results of these tests should be realistically evaluated to avoid over-referral.
      (1) Massachusetts Vision Test
      (2) American Optical Co. Sight Screener
      (3) Keystone Telebinocular
      (4) Bausch and Lomb Orthorater
2. It is suggested that as an additional part of screening procedures in testing distant acuity, a pair of plus 2.00 spherical lenses be placed before both eyes to reveal high degrees of hyperopia.
3. The value of tests for heterophoria and stereopsis, as applied to school vision screening programs, is doubtful.
4. Grades to be screened:
   It is suggested that, as a minimum program, Grades 1, 4, and 7 be screened annually. The Vision Program can conveniently be synchronized with the Audiometric Screening Program.

C. Administration:

1. The public health nurse is recommended as director of the program.
2. Volunteer lay women, trained by the medical committee and/or the public health nurse under the direction of the medical committee, to administer initial vision screening tests.
3. Public health nurse or specially trained and proficient lay person to recheck children who fail the initial tests.
4. All children having unsatisfactory vision tests as well as those having visible lid, muscle, or other ocular defects should be referred for further eye examination and refraction.
   a. Form letter to parents of the child with a visual defect, advising further examination by an eye doctor.
      (1) Form to include space for the examining doctor to record his recommendations; to be returned to the Planning Committee by the doctor.
5. Follow-up letters and visits by public health nurse if referral recommendation is ignored.
6. Liaison between public health nurse and classroom teacher.

D. Employment of special funds to facilitate program:

1. Service clubs and private organizations to be interested.
2. Uses of such funds:
   a. Purchase of screening test equipment.
   b. Clerical, stationery, and mailing costs.
   c. Financial aid for professional fees and glasses in needy cases.

(See next page for suggested forms.)

* Approved by Divisions on Hearing and Vision and School Health of State Medical Society of Wisconsin Commission on State Departments, April 1953.

SUGGESTED FORMS FOR VISION PROGRAM

Form 1

FORM LETTER

NAME _____ DATE _____

ADDRESS _____ AGE _____

Dear Parents:

Your child was given a test at a vision screening center recently. It showed that he may have some vision trouble. This test is not final. It only selects those children who may need further attention. If your child has not had an eye examination in the last six months or is not under professional care for his eyes, it is advised that he go to an eye doctor for an examination. He can tell what treatment, if any, is needed.

Please take this letter to the doctor's office with you. He will complete the form below and return it to the _____ Public Health Nurse's Office.

Sincerely yours,

_____ Vision Committee

EYE DOCTOR'S REPORT

Note to Doctor: This is the _____ year of the vision program in the schools of _____. In order to evaluate the effectiveness of this program, we are asking you to please fill in this form and return it to:

_____ Public Health Nurse's Office

_____

DATE _____

I have given the above named child an eye examination.

Glasses recommended _____ Not recommended _____.

℞	Vision with correction	Vision without correction
O.D. _____	20/	20/
O.S. _____	20/	20/

Remarks:

Signed _____

Address _____

Form 2

FORM LETTER TO PARENTS OF CHILDREN NOT SCREEN TESTED

Dear Parents:

A vision screening program is being conducted in your child's school. The program is planned in an attempt to find those children who have vision problems which are not corrected. Those children who are wearing glasses have not been tested.

We would like to urge you, however, to keep your child under your eye doctor's supervision, and if your child has not had his eyes examined in the last two years, to do so. If you have any questions, please contact your public health nurse.

Sincerely,

_____ Vision Committee

THE MEDICAL FORUM

COUNCIL MAKES IMPORTANT DECISIONS AT MAY MEETING

OLD MEDICAL DOCUMENTS are scanned by Dr. W. D. Stovall, chairman of the State Medical Society's new Section on Medical History. He will work closely with Dr. Clifford L. Lord, left, director of the State Historical Society and Don McNell, right, who has headed the medical history project of the past two years and is now field supervisor for the Historical Society.

SMS OFFICE WILL BE HEADQUARTERS FOR NURSE RECRUITMENT ACTIVITIES

Madison, May 23.—Plans for establishing a central office for nurse recruitment activities and adoption of several new benefits offered under Blue Shield service were among the results of the State Medical Society's Council meeting in Madison May 23 and 24.

Mrs. Victor Falk of Edgerton, Nurse Recruitment Chairman of the Woman's Auxiliary to the State Medical Society, appeared before the Council to ask that a file drawer at medical society headquarters and the part-time services of a member of the secretarial staff be placed at the disposal of her committee. It is her hope that all the correspondence on this important subject can be kept up to date in this way.

Mrs. Falk reported that the chief project her committee has in mind for next year is the establishment of Future Nurses' Clubs in the secondary schools. During the past year, the committee has conducted a number of institutes for the training of speakers who can then address high school audiences and impart accurate information to the students about entering nursing school.

Twelve of these institutes were held, with a total attendance of 344 persons. Speaking engagements were filled at 116 high school career planning meetings after termination of the courses.

Mrs. Falk's committee also assisted in placing nearly 500 nursing school information notebooks in high schools, and has raised over $3,000 for scholarships and loans to nursing school students.

The Commission on Prepaid Plans reported several benefit

(Continued on next page)

Dr. Stovall Chosen As Chairman of Section On Medical History

Madison, May 23.—A new Section on Medical History of the State Medical Society has come into being by action of the Council.

Dr. W. D. Stovall, Madison, was elected chairman of the new section and Dr. P. R. Minahan, Green Bay, vice-chairman. C. H. Crownhart, secretary of the society, will be secretary–treasurer. Left vacant for later appointment by the chairman were the positions of manuscript chairman, collection chairman and membership chairman.

The Section on Medical History will be supported by voluntary dues of $5. per year from each physician who elects to join. The fiscal year will begin July 1. The membership of the medical society will be notified by letter of the establishment of this new section. Prospective members will be asked to make their checks out to the Section on Medical History. Membership certificates will be issued.

The section's projects will include the development of a book of Wisconsin's medical history, production of bulletins for the profession and the general public and development of a cooperative program between state and local organizations relative to institutional history, local medical history and the history of various medical personalities.

It will prepare an exhibit for the annual meeting in Milwaukee October 5, 6 and 7, and one for the annual meeting of the auxiliary at the same time. It may take up the work of completing the Fort Crawford project at Prairie du Chien at some future date. Fort Crawford was the site of the famous Beaumont case early in Wisconsin's medical history.

The Historical Committee, consisting of Drs. H. Kent Tenney, Madison; E. M. Dessloch, Prairie du Chien; G. Kasten Tallmadge, Milwaukee; P. R. Minahan, Green

(Continued on next page)

SMS OFFICE . . .

(Continued from last page)

changes now, or soon to be, in effect. These included:

1. Surgical benefits, including anesthesia and radiology, available to the newborn beginning the first day. These benefits may be obtained by rider, at extra cost. Without the rider, they are not available until the 14th day.

2. By rider, and at extra cost, medical care for in-hospital cases may be extended to 70 or 120 days to conform with existing Blue Cross contracts providing hospitalization for like periods.

3. By rider, and at additional cost, increased benefits may be purchased by a clearly defined segment of employees within a group, such as the executives. All elements of the "A" schedule can be increased in multiples of 25 per cent up to a maximum of 100 per cent. "Full payment" will not apply, but direct payment to participating physicians will be retained.

A Physicians' Manual, explaining all the policies and fee schedules, is in preparation and is expected to be ready in the fall.

A community enrollment program which may be employed either on an individual or a family basis is to be developed to cover those not now eligible through group programs.

A comprehensive advertising program costing approximately $67,000 has been scheduled to cover all daily newspapers in the state, 70 weeklies and 21 radio stations.

It was also reported to the Council that the Commission on Prepaid Plans has authorized setting up some form of catastrophic insurance providing services over and above those available under the standard Blue Shield–Blue Cross programs.

A total of 282,906 persons are now covered by Blue Shield contracts in Wisconsin.

The Wisconsin Society of Pathologists presented a resolution to the Council to the effect that their society and the Section on Pathology of the State Medical Society should pledge jointly to respect the priority of position in an institution of a pathologist who is called to duty with the Armed Forces and must be replaced during his absence. The resolution suggested that parallel action should be taken by organized radiologists and physiatrists.

It was announced that in connection with the annual meeting in Milwaukee October 5, 6 and 7, there will be a special art exhibit —a project which has been under way in cooperation with the Milwaukee Art Institute for almost two years. An additional $500 to be charged to the account on health exhibits and conferences was appropriated for this project.

The Council received a recommendation from the Interim Committee that the by-laws be changed to provide for automatic revocation of membership in the society of physicians whose licenses to practice medicine have been suspended or revoked.

COUNCIL ADOPTS INCREASES UNDER PROVIDENT PLAN

Madison, May 23.—Increases in the benefits and rates of the group disability plan under which members of the State Medical Society are insured have been approved by the Council.

Changes suggested by the Provident Life and Accident Insurance Company, underwriters of the plan, which received Council approval, are as follows:

1. Payment for the first fifteen days of disability will cover only as many of those days as are actually spent in the hospital.

2. No hospital indemnity payments will be made in cases where an insured member is confined to a federal or state institution where confinement does not cost the patient anything.

3. A new partial disability benefit has been added at one-half the total disability rate where total disability payments have existed for at least 30 days. A partially disabled physician may receive benefits for no more than 26 weeks. Addition of this benefit will increase the rate by 10 per cent, bringing the cost of the contract to $127.60 annually.

An optional added benefit of $25 a week is offered to members under age 60, for a further increase in premium. This added benefit is available only to physicians who have less than $150 weekly indemnity in professional group coverage.

DR. STOVALL CHOSEN . . .

(Continued from last page)

Bay and E. E. Kidder, Stephens Point, has been working with the State Historical Society for several years. This committee initiated the State Historical Society's project for collecting "grass-roots" medical history materials, and the medical society has helped to finance the work.

The historical society will now continue its work without further financial aid, but the new Section on Medical History will work closely with its personnel.

Details of the medical society's historical project to date were presented to the Council by Dr. C. L. Lord, director of the State Historical Society and Don McNeil, who has been specializing in medical history research.

President's Campaign Special Carried a Masseur, Not a Chiro

Washington, May 10.—Claims in chiropractic magazines that President Eisenhower had a daily check-up by a chiropractor while riding his campaign special have been disproved both by Sherman Adams, special assistant to the President, and Major General Howard McC. Snyder, the President's personal physician.

Both of these sources stated the President had daily treatments but that they were given, not by a chiropractor, but by a masseur.

Said General Snyder in a letter to Dr. Morris Weintrob of a New York county medical society, "The man . . . was a simple masseur, uneducated and with no desire to pose as a chiropractor. He was . . . exceedingly loyal and willing and a very good masseur. If you care to publish this statement anywhere, you can quote me."

Charity Patients Claim 7 Hours of MD's Week

Rutherford, N. J., May 6.—The average U. S. physician gives seven hours a week, about 12 per cent of his working hours, to charity patients, according to *Medical Economics*, national business magazine for doctors.

DR. H. KENT TENNEY, MADISON, president-elect of the State Medical Society, presents the first copy of the vocational guidance brochure "Medical Associates" to R. O. Christoffersen, principal of Madison West High School and Miss Betty Perego, West career counselor. Second from right is David Reynolds, administrator of Madison General Hospital and vice-president of the Wisconsin Hospital Association, which cooperated in production of the brochure.

Careers Associated With Medicine Subject Of New SMS Vocational Guidance Brochure

Madison, June 1.—With the intention of attracting this spring's high school and college graduates to occupations associated with the medical profession, the State Medical Society mailed out its new brochure "Medical Associates" in May.

This booklet includes 28 pages of attractive illustrations and information regarding the careers of nurses, dietitians, therapists, technicians, veterinarians, pharmacists, dental associates and various categories of public health associates. It also includes a large folding chart which gives up-to-date details concerning these occupations, such as entrance requirements for training, schools where courses are offered, salary that can be expected and the like.

Copies of this booklet may be obtained by writing to the State Medical Society.

The "Medical Associates" brochure has been distributed to all high schools, colleges, libraries, hospitals and vocational guidance counselors in the state. It has received favorable editorial comment from several of the state's newspapers, which has resulted in a number of personal requests for copies.

The brochure was distributed in Milwaukee County by the Medical Society of Milwaukee County and the Hospital Council of Milwaukee County.

Magazine for Druggists Gets AMA Cooperation

Chicago, May 26.—The AMA is cooperating in the preparation of a new magazine, "Beauty and Health," which will be distributed by druggists to their customers.

This magazine will carry health education articles and teach the dangers of self-medication. The AMA will provide medical information for articles, and will check all medical copy for accuracy.

Town Reappointed As Basic Science Member

Madison, May 1.—George G. Town, Waukesha, has been reappointed by Governor Kohler to the State Board of Examiners in Basic Sciences. His appointment was confirmed by unanimous consent of the state Senate. His term runs to April 1, 1959.

Reappointed to the State Board of Examiners in Chiropractic was E. J. Wallschlaeger, La Crosse.

County Highlights Call System's Importance

Harrisburg, Pa., May 2.—The Lehigh County Medical Bulletin points up the importance of emergency call service by running statistics on the number of emergency calls made each month.

They ascertained that there were 36 emergency calls, or 1.3 per day in February. They found that the emergency call service had been contacted 29 times because the family physician could not be reached, 6 times because the family had no physician, and once for an unknown reason.

The report is concluded by the following statement in bold type:

"No one is expected to work 24 hours a day—But everyone is expected to have an alternate when he is not available."

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

AMA OUTLINES ITS POSITION ON PROPOSED LEGISLATION

Madison, June 1.—The AMA's position on a wide variety of health measures which have come before the 83rd Congress has been announced by Dr. Frank E. Wilson, director of the AMA Washington office.

Active approval is given to HR 10 which provides **tax postponement for the self-employed** to create retirement annuities. This bill, similar to the Reed–Keogh bills of the last congress, would allow the self-employed to deduct 10 per cent of net income or $7,500, whichever is the lesser, but which is not to exceed $150,000 in a man's lifetime.

S 70 and HR 97, which would **credit service of co-belligerents** in the doctor draft also has active approval.

Approval has also been given to the following bills:

HR 474, which provides several types of **medical expense deductions** for income tax purposes. All medical expense could be deducted from income of $2,000 or less, all but 1 per cent if income is between $2,000 and $4,000 and so on in a sliding scale up to 5 per cent for incomes over $10,000. Premiums for health and accident insurance are included.

HR 482, which is a separate bill allowing **tax deduction for health insurance premiums.** A total of 90 per cent may be deducted if income is less than $2,000, and the scale slides to 60 per cent for incomes over $10,000.

HR 1414, which permits **reciprocal transfer of hospitals** and facilities between the Veterans Administration and the Department of Defense. This is approved on the grounds that it will save money.

HR 2243, which would allow **all medical expenses** up to $1,250 to be deducted for income tax purposes.

S 967 and HR 3171, which call for **extension of the Hill Burton hospital construction act** to June 30, 1960.

HR 2955, which allows **draft credit for doctors,** who could count the time spent in service before they became doctors or entered ASTP or V 12 courses. This bill was drafted by an M.D.—Judd of Minnesota (R), who also drafted HR 303 to transfer Indian hospitals to the U. S. Public Health Service jurisdiction.

S 1514 and HR 4406, which set up a **commission on government functions and fiscal resources.** The AMA would like to see whether federal aid to a great many programs is justified.

S 932 and two similar bills, which allow **veterinarians** to be commissioned as First Lieutenants. As of now, they can only be commissioned Second Lieutenants.

S 1531, Saltonstall's **extension of the doctor draft.** However, the AMA approves its extension for only one year, rather than two.

The AMA approves in principle HR 116 prohibiting the **transportation and sale of fireworks.** It approves of S 106 which sets up a committee to study **federal-state relationships.**

It approves the principle of HR 633 which would set up a **federal board of hospitalization,** but disapproves of the bill itself because it includes only government bureau heads and no civilian on the board

Of interest to physicians is HR 4393 which would allow expenses incurred in acquiring post-graduate professional education to be deducted from taxable income.

The AMA is actively opposed to a number of bills for extension of Social Security, increasing presumption of service connection in many illnesses of veterans, and extension of hospitalization to cover all retired military personnel, all servicemen's dependents and the dependents of coastguard personnel. It opposes federal aid to medical, public health and nursing education on the grounds that these fields will lose their independence under government dictation.

Also opposed by the AMA are the following bills:

S 93, **which would provide federal aid to states for promoting voluntary health insurance,** based on ability to pay.

S 156, S 188, HR 2253 and HR 2449 which would establish, respectively, an **epilepsy institute, a vast cancer research project, an institute for polio and a system of clinics for alcoholics and narcotics addicts.** All these things are provided for through the United States Public Health Service or through private and other means, according to the AMA.

HR 258, which provides for **child life research.** The Children's Bureau now has the authority to make such a study if needed.

S 370 and several similar bills providing 16,000 or more **veterans beds.** The AMA is convinced that if abuses of their use are stopped, the VA now has an adequate number of hospital beds.

The AMA is also opposed to S 994 pending a report from the committee on federal-state relationships. This bill has to do with **federal aid to local public health units.**

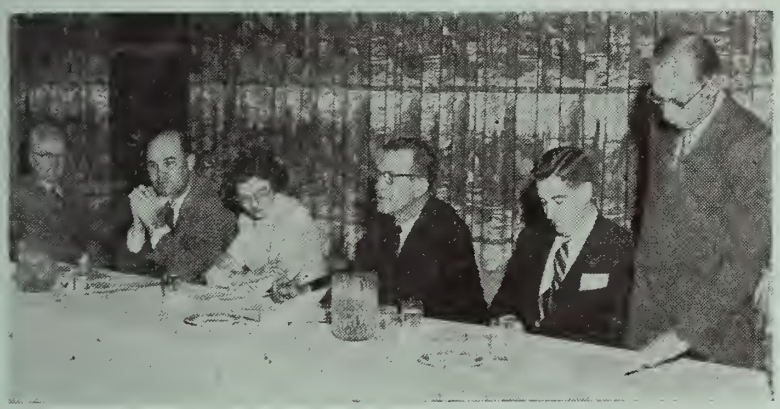
It is likewise opposed to the addition of chiropractors and optometrists to VA, and the usual **omnibus bill for socialized medicine** and national compulsory health insurance contributed by Dingell (D, Mich.)

Other health legislation put forth by the 83rd Congress includes research in causes and effects of air pollution, study of problems of the aged, investigation of VA, establishment of a standing committee on veterans' affairs, establishment of an independent agency for the handicapped under the department of labor, a military officer candidate training program for nurse trainees, commissioning of men nurses in Armed Forces, establishment of a United States Medical and Dental Academy, the awarding of MS and DS degrees by Army Medical Service Graduate School at Walter Reed hospital.

H Res 141 would require an investigation into selective service's designation of the physically unfit. Two new wrinkles in proposed social security legislation would include (1) everybody and (2) such self-employed as physicians, dentists, architects, engineers and funeral directors. Still another would make social security elective with these groups.

S 601 will allow inspectors from the Food and Drug administration to inspect factories without permission of the owner, upon written notice that they are going to appear.

Much of the legislation submitted by Dingell and by Rogers, R, Mass. is opposed by AMA. At the opposite extreme, legislation sponsored by Dr. Judd or by Senator Taft, R, Ohio, is almost always in line with AMA policy.



AT THE MILWAUKEE MEDICAL-PRESS CONFERENCE, Harvey Schwandner, managing editor of the Milwaukee Journal, spoke first. Other panel members shown are, left to right, Joseph Norby, hospital administration consultant; Dr. Joseph S. Devitt, Milwaukee, chairman of the Milwaukee County Society's public relations committee; Miss Helen Burrowes, Milwaukee Sentinel reporter; Dr. J. C. Griffith, president of the State Medical Society, who introduced the speakers, and Judge Leo B. Hanley of Milwaukee Civil Court. Photo Courtesy of John Kadousky, Medical Society of Milwaukee County.

Need For Mutual Understanding Stressed At Milwaukee Medical-Press Conference

Milwaukee, May 28.—Approximately 75 physicians, newspapermen, hospital administrators and representatives of radio stations attended a medical-press conference held in Milwaukee, May 28.

A panel discussion was followed by supper and a general discussion.

Harvey Schwandner, city editor of the Milwaukee Journal, led off the panel, explaining what material newspapers must get from hospitals and what is considered "privileged material" which is necessary information in all police cases.

Miss Helen Burrowes, Milwaukee Sentinel reporter, explained that a good reporter must have facts in order to make a story accurate. She explained that doctors are often reluctant to give out information, but that they should realize that the truth will be presented if it is given to them. She explained that reporters must sometimes dramatize facts to make a story readable, but that they are conscientious about not sacrificing facts for glamour in reporting.

Dr. Joseph S. Devitt, chairman of the public relations committee of the Milwaukee County Society, presented the physician's point of view, explaining that there must be mutual understanding between physicians and the press because the doctor usually wants to cooperate, but must consider the secrecy that is understood in the doctor–patient relationship. Often certain facts are being withheld from the public at the request of the patient or his family, Dr. Devitt explained. In such cases, the medical code of ethics requires the doctor to refuse information.

Joseph Norby, consultant in hospital administration, who was long connected with Milwaukee's Columbia hospital, explained that the hospital, like the doctor, is often required by the patient or his family to keep silent, and that information leaking prematurely may actually be of financial importance to many people, as in the case of an industrial executive's illness which, when it became know, effected the stock market.

Mr. Norby emphasized the need for the doctor and the hospital to trust representatives of the press with "off-the-record" information in certain instances, so that they can be made to understand why certain facts must not be made public. He said he had never known of a case of the Milwaukee press violating a promise not to print certain facts when they knew why silence was requested.

Judge Leo B. Hanley spoke last on the panel, backing up physicians on their stand that great care must be taken regarding what information may be released.

CIO WANTS TO HELP SHAPE POLICIES OF PREPAID INSURANCE

Washington, May 7.—The CIO wants wider representation on Blue Cross–Blue Shield policy making boards with the aim of using prepaid insurance for preventive and diagnostic care, according to the union's *Economic Outlook.*

The Outlook lists a number of health objectives which it feels can be won through collective bargaining. These include healthier and safer working conditions, improved protection against the costs of hospitalization and medical care; extension of existing plans to cover more workers with similar coverage for dependents, plus extension and improvement of cash sickness payments.

"The task is only partly that of convincing the employer that he should agree to bear the costs of improved programs, either entirely or on a shared basis," the Outlook said. "It is equally important that the terms of plans that are being paid for are improved so as to overcome the many shortcomings that now exist."

The Outlook made it clear that there would be no relaxation in the CIO's fight for national health insurance.

PROFESSIONAL BUSINESS SERVICE
State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

MEDICAL CARE AND WHERE MEDICAL DOLLAR GOES ARE EXHIBIT SUBJECTS

Chicago, May 6.—The Bureau of Exhibits of the AMA has announced the availability of two new exhibits which may be borrowed for showings at fairs, conventions and the like. They may be obtained for the cost of freight from Chicago and back.

Seven Separate Units

One of the exhibits, entitled "You and Your Medical Care," is composed of seven separate units using three-dimensional carved figures to portray suggested programs of the American Medical Association to make medical care more readily available to all persons. These include emergency call service, good office service, proper diagnostic procedures, health education, medical expense insurance and the like. The shipping case of each unit serves as its pedestal. The whole exhibit weighs 1,118 pounds.

The other, entitled "Where Your Medical Dollar Goes" is a turntable type of exhibit with a large silver dollar divided into pie-shaped pieces. Each piece is surmounted by a three-dimensional figure representing where that part of the dollar goes. This exhibit weighs only 154 pounds.

Either of these exhibits may be scheduled by writing the American Medical Association Bureau of Exhibits or the State Medical Society. It is well to reserve them as far in advance as possible.

ADVISORY COMMITTEE TO CONTINUE SERVING

Washington, D. C., May 6.—President Eisenhower has ask d the members of the Health Resources Advisory Committee of the Office of Defense Mobilization, who also serve as the National Advisory Committee to Selective Service, to continue in their present capacities. Dr. James C. Sargent, Milwaukee, is a member of this committee, of which Dr. How ard Rusk of the New York University medical faculty is chairman.

Announcement of this request by the President was made by Arthur S. Flemming, Director of Defense Mobilization.

The State Committee, which will continue in office, includes Drs. F. L. Weston and C. N. Neupert, Madison, physician members; Dr. R. J. Mashek, Milwaukee, dentist member; Dr. B. A. Beach, Madison, veterinarian member and Miss Ione Rowley, Madison, nurse member.

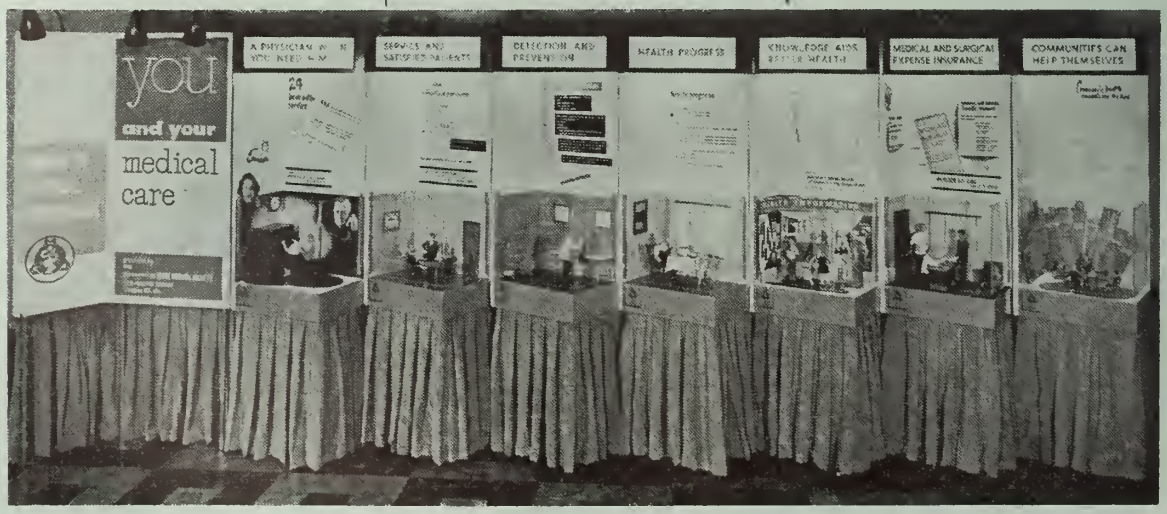
Plymouth Club Honors Dr. Henry Deicher

Plymouth, May 25.—A campaign to create a $5,000 medical school scholarship in honor of Dr. Henry Deicher has been started by the Plymouth Kiwanis Club.

The scholarship is being created as a living memorial to Doctor Deicher's fifty years of service to the Plymouth community. Doctor Deicher started practice in Plymouth in 1903 and celebrates his 50th year of practice in June.

Funds raised by the Kiwanis Club will be available to Plymouth high school students who wish to go to medical school. The fund will be a revolving scholarship with students borrowing against it to meet their financial needs during medical education. They will be asked to repay the loan after they have set up practice.

Contributions are being solicited from business and industrial firms, former patients, more than 3,000 babies brought into the world by Doctor Deicher, and from all interested parties.



"WAR WITHOUT GUNS"—GET YOUR COPY NOW!

"War Without Guns" is a beautifully illustrated historical record of the service rendered to the Armed Forces by Wisconsin Physicians during World War II.

Several hundred copies still remain from the first printers run, and will now be sold at $1 each—substantially below cost—to anyone interested, in order to clear overtaxed storage facilities.

At this low price, purchase of a copy for each member of a physician's family is practically a "must." His military record will always be a source of pride to each of them.

Each copy will also have historical value as a record of military medical methods and accomplishments of this period.

As an item of waiting room literature, "War Without Guns" has considerable public relations value.

Please send your check, $1 for each copy, to the Wisconsin Medical Journal with your request.

WAYS TO IMPROVE NURSING EDUCATION BASIS OF DISCUSSIONS IN MILWAUKEE

Milwaukee, May 14.—Ways of improving nursing education and service were the focus of discussion at a 3-day regional meeting of the National League for Nursing in Milwaukee, which was attended by 152 members from Wisconsin, Illinois and Michigan.

One feature of the conference was a group of reports on regional activities designed to stimulate experimentation in nursing education methods.

Problems arising out of nursing school accrediting service were high-lighted in a series of group meetings. Actual problems which have been encountered by the League for Nursing's accrediting service had been submitted in advance to the various groups. They had discussed proper solutions among themselves and come to the group meetings prepared for give and take on the conclusions they had reached.

A report was submitted by a sub-committee of the American Nurses' Association which had been studying the possible establishment of more flexible standards to be used by State Boards of Nursing in evaluating their nursing schools. One of the suggestions brought forward by this committee had to do with the scheduling of length of courses and hours allotted to each study. The subcommittee felt that hours should not be specified, and that only a very generalized list of courses should be required.

According to Miss Adele Stahl, director of the State Department of Nurses, Wisconsin nurses present felt that to remove all restrictions on subject matter at present would be to pull an important prop from under some of the weaker institutions. However, the nursing profession hopes eventually to develop a standard of flexibility in education comparable to that which is now enjoyed by general education, according to Miss Stahl.

"Last time," said Miss Stahl, "people came to this meeting ready to defend their own sets of standards. This year, people were really seeking help with their problems and arrived in a receptive frame of mind. This made for a really good exchange of ideas. Special interest groups, which met after the close of the meeting proper, were nearly as well attended as the conference itself."

Miss Janet Jennings, president of the Wisconsin League for Nursing, opened the conference with a speech of welcome. This meeting was one of 20 being held in various regions during the spring and summer.

Survey Shows 80 Per Cent of U.S. Families Have No Medical Debts

Most people—over 80 per cent of them—have no medical debts whatsoever.

This fact was brought out by a recent study based on figures gathered for the Federal Reserve Board by the Survey Research Center of the University of Michigan.

Whether the 80 per cent had been ill within the stated period is not recorded. If they were, they must have paid their bills in cash or been covered by some sort of insurance protection such as Blue Shield–Blue Cross.

Out of 53,000,000 families, about one million owed debts from $200 to $1,000, while another 200,000 owed more than $1,000. About 9,000,000 families were reported in debt in amounts varying from $1. to $200, or little enough to manage easily with intelligent budgeting.

According to a recent Saturday Evening Post article, the advocates of socialized medicine see fit to turn the whole problem upside-down and focus attention on the unfortunate 3 per cent who are deeply in debt because of illness. operation.

"The 3 per cent," the Post says "must be described as the norm in order to justify the infliction of another expensive bureaucracy on the suffering taxpayer. Any other way of helping the people who really need help is dismissed as a half measure.

"This business of reversing any sensible approach to the relations of the people and their government was spotted long ago by Grover Cleveland. That sage remarked that it was the business of the people to support the government, and not of the government to support the people.

"As far as the medical-debt problem goes, there is nothing in the record to justify any all-out intervention by Washington officials along the lines of the British National Health Service."

(Reprinted by special permission of *The Saturday Evening Post.* Copyright 1953 by the Curtis Publishing Company.)

Wisconsin Lawmakers Introduce Four Bills Touching Health Field

Madison, June 1.—Wisconsin lawmakers of the 83rd Congress have concerned themselves mostly with matters outside the health and welfare fields. A study of legislation they have introduced turns up the following:

HJ Res. 79, introduced by Rep. Lawrence H. Smith, Racine, is similar to the Bricker resolution of the last Congress which was reintroduced to the 83rd Congress by Bricker and a number of other senators. It outlaws any treaties that might supersede the authority of the laws of the United States or of the states themselves.

HR 5022, introduced by Rep. Charles J. Kersten, Whitefish Bay, would broaden income tax deductions for medical expense. Kersten's bill would allow deduction of all expense in excess of 2 per cent of income, and would permit the deduction of the cost of all voluntary health insurance, including hospitalization insurance.

HR 3554, introduced by Rep. Clement J. Zablocki, Milwaukee, would broaden the Social Security Act on four points. It would extend disability benefits to the totally disabled taxpayer and to his wife and minor children. It would lower the retirement age of women for Social Security purposes from 65 to 60, and it would increase from $75 to $100 a month the amount retired individuals can earn between the ages of 65 and 75 without losing Social Security benefits.

Zablocki also sought to amend the medical expense provisions of income tax law to allow deductions for the costs of wigs and transformations.

Final Wording of Draft Bill for Doctors to Be Decided in Conference

Washington, June 1.—Final wording of the doctor draft bill will be worked out in a conference committee. The bill passed the Senate May 28 and the House passed its version May 12.

The Senate bill contains a provision for retaining the $100 a month special pay for physicians and dentists and extends this to veterinarians. The House bill omits both these factors. A separate bill was to supply the special pay.

Under the House bill, a man with 12 months prior service since September 16, 1940, could be called for only 17 months. Men with at least 21 months service since that time could not be recalled at all. **In defining "prior service," the bill does not specify that time must be counted before or after completion of medical training.** Priority 2 men with 18 months of prior service would move to Priority 4. All men on active duty who would not have been called had this bill been law would be released within 90 days from July 1, when the law goes into effect.

The Senate bill sets up a sliding scale of service requirements, as follows:

If less than 6 months' prior service, 24 months service would be required.

If more than 6 months but less than 9, 21 months required.

If more than 9 but less than 12, 19 months required.

If more than 12 but less than 15, 17 months required.

If more than 15 but less than 21, 14 months required.

In other respects, the House and Senate bills are similar.

SORRY! Wrong Doctor!

THE ABOVE PICTURE of Dr. Samuel L. Henke, Eau Claire, vice-president of the State Board of Health, appeared in the May Medical Forum incorrectly labeled Dr. Frederick W. Henke, Shawano. Apologies to all concerned.

URGE YOUR PATIENTS TO HEAR BROADCASTS!

Since concern over the polio situation mounts in the late summer months, every effort is being made to explain to the public that gamma globulin may be secured only under certain circumstances and through public health authorities.

To aid in public understanding of the question, there will be two March of Medicine radio programs on the subject between the dates of July 11 and July 23. The first will deal with the disease and the second with the usage and distribution of gamma globulin.

Please urge your patients to listen to these informative programs.

State MD's Attend AMA Meeting in New York

Madison, June 5.—Wisconsin physicians took part in a number of the scientific sessions of the American Medical Association meeting in New York, June 1 through 5.

Dr. Hans H. Reese, Madison, was delegate of the Section on Nervous and Mental Diseases.

Dr. Walter P. Blount, Milwaukee, was a member of the executive committee of the Section on Orthopedic Surgery. He took part in a discussion on flake fractures of the astragalus.

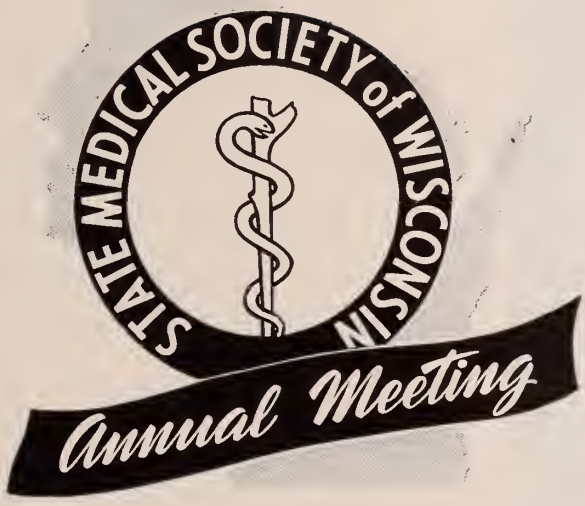
Dr. W. A. D. Anderson, Milwaukee, opened the discussion in his group on the subject of thyroid cancer.

Delegates to the AMA meeting were Drs. S. E. Gavin, Fond du Lac; W. D. Stovall, Madison and J. C. Griffith, Milwaukee, president of the State Medical Society.

Seven New Physicians Added to Blue Cross Corporate Membership

Seven physicians have been appointed to the corporate membership of Blue Cross, and their names submitted for approval by the State Medical Society in accordance with the statute under which Associated Hospital Service, Inc. operates.

Those whose names were approved by the Council at its May meeting include Drs. L. J. Keenan, Fond du Lac; Donald G. Dieter, Madison; M. K. Mookerjee, Milwaukee; W. A. Wagner, Oshkosh; Harry Mannis, Sparta; Donald F. Jarvis, Tomahawk and C. E. Kampine, Marathon.



GUEST SPEAKER ROSTER

On the following pages are listed the outstanding guest speakers who will contribute to the Annual Meeting Program in Milwaukee on October 6–7–8 (Tuesday, Wednesday, and Thursday).

The program has been arranged so that special fields of medical practice will be emphasized each day. All programs are open to the entire membership of the State Medical Society.

TUESDAY, OCT. 6

Anesthesia

▪

Medicine and Psychiatry

▪

Orthopedics

WEDNESDAY, OCT. 7

Cardiac and Pulmonary Diseases

▪

Obstetrics and Gynecology

▪

Pathology

THURSDAY, OCT. 8

Pediatrics

▪

Radiology

▪

Surgery

▪

Ophthalmology and Otolaryngology

Watch Your Mail on July 15

On July 15 you will receive a special announcement of all Round Tables and other special events requiring advance reservations. Be sure you make your reservations promptly.

Gue

1953 Annu

■ **JOSEPH C. AUB, M.D., Boston**

Professor of Research Medicine, Harvard Medical School

THE RELATIONSHIP OF HORMONES TO CARCINOMA: Tuesday a.m., Oct. 6

(Sponsored by Wisconsin Division, American Cancer Society)

THE METABOLISM OF BONE: Round Table, Tuesday, Oct. 6

■ ■ ■

■ **OSCAR J. BECKER, M.D., Chicago**

Assistant Professor of Maxillo-Facial Surgery, College of Medicine, University of Illinois

THE SEPTUM IN RELATION TO RHINOPLASTIC SURGERY: Thursday p.m., Oct 8

(Section on Ophthalmology and Otolaryngology)

■ ■ ■

■ **DAVID A. BOYD, JR., M.D., Rochester, Minn.**

Professor of Psychiatry, Minnesota Graduate School

ROGERS MEMORIAL LECTURE: Tuesday a.m., Oct. 6

RECOGNITION OF THE DEPRESSED MENTAL STATE: Round Table (with Owen Clark, M.D., Milwaukee) Tuesday, Oct. 6

■ ■ ■

■ **J. BARRETT BROWN, M.D., St. Louis**

Professor of Clinical Surgery, Washington University Medical School

HOMOGRAFTS, FRESH AND POSTMORTEM, AS "BIOLOGICAL DRESSINGS" FOR BURNS: Thursday a.m., Oct. 8

SURGICAL REPAIR OF RADIATION LESIONS, INCLUDING THOSE OF ATOMIC ORIGIN: Round Table, Thursday, Oct. 8

Speakers

Meeting

■ **HERMANN M. BURIAN, M.D., Iowa City**

Associate Professor of Ophthalmology, State University of Iowa College of Medicine

EVALUATION OF DIAGNOSTIC METHODS IN THE EXAMINATION OF NEUROMUSCULAR ANOMALIES OF THE EYE: Thursday p.m., Oct. 8

(Section on Ophthalmology and Otolaryngology)

■ ■ ■

■ **CONRAD G. COLLINS, M.D., New Orleans**

Professor and Chairman, Department of Obstetrics and Gynecology, Tulane University School of Medicine

VASCULAR COMPLICATIONS OF PREGNANCY: Wednesday a.m., Oct. 7.

MANAGEMENT OF PREECLAMPSIA AND ECLAMPSIA: Round Table, Wednesday, Oct. 7

NEWER METHODS OF DIAGNOSIS AND THERAPY IN OFFICE GYNECOLOGY: Wednesday p.m., Oct. 7

■ ■ ■

■ **BRIG. GEN. ELBERT DE COURSEY, M.D., Washington, D. C.**

Director, Armed Forces Institute of Pathology

THE PATHOLOGY OF HEMORRHAGIC FEVER: Wednesday a.m., Oct. 7

TISSUE REACTION TO IONIZING RADIATION: Round Table, Wednesday, Oct. 7

■ ■ ■

■ **CHARLES K. FRIEDBERG, M.D., New York City**

Assistant Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University

ELECTROLYTE DISTURBANCES OF HEART DISEASE: Wednesday a.m., Oct. 7

(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

MANAGEMENT OF INTRACTABLE HEART FAILURE: Round Table, Wednesday, Oct. 7

G. EDMUND HAGGART, M.D., Boston

Chief of Department of Orthopedic Surgery, Lahey Clinic

MANAGEMENT OF LOW BACK AND SCIATIC BACK PAIN: Tuesday a.m., Oct. 6

(Further discussion of subject at Round Table at noon of same day)

■ ■ ■

ROBERT M. JANES, M.D., Toronto, Canada

Chairman and Professor, Department of Surgery, University of Toronto

BREAST CARCINOMA: Thursday a.m., Oct. 8
(Sponsored by Milwaukee Division, American Cancer Society)

ROUNDED SHADOWS IN THE CHEST: Thursday p.m., Oct. 8
(Closing General Session)

■ ■ ■

O. P. KIMBALL, M.D., Cleveland

Chief of Medical Staff, Doctors Clinic, Cleveland, Ohio

THE GENETICS OF EPILEPSY: Thursday a.m., Oct. 8

EPILEPSY IN RELATION TO INHERITANCE: Round Table, Thursday, Oct. 8

■ ■ ■

TRAIAN LEUCUTIA, M.D., Detroit

Assistant Professor of Radiology, Wayne University

COMPARATIVE EVALUATION OF DEEP ROENTGEN THERAPY AND SUPERVOLTAGE ROENTGEN THERAPY: Thursday a.m., Oct. 8

PLESIOTHERAPY AND TELETHERAPY WITH VARIOUS RADIOACTIVE SOURCES: Round Table, Thursday, Oct. 8

NEWER DEVELOPMENTS IN RADIATION AND CHEMOTHERAPY FOR THE TREATMENT OF CANCER: Thursday p.m., Oct. 8

(Closing General Session)

■ **WILLIAM O. McQUISTON, M.D., Peoria, Ill.**

Instructor in Surgery, Northwestern University

ANESTHESIA FOR CARDIAC SURGERY: Tuesday a.m., Oct. 6

PEDIATRIC ANESTHESIA: Round Table, Tuesday, Oct. 6

■ ■ ■

■ **JOHN W. PENDER, M.D., Rochester, Minn.**

Assistant Professor of Anesthesiology, Mayo Foundation

GENERAL ANESTHESIA FOR THE PATIENT WITH CARDIAC DISEASE: Tuesday a.m., Oct. 6

COMPLICATIONS IN ANESTHESIA RELATED TO CORTISONE THERAPY: Tuesday p.m., Oct. 6

■ ■ ■

■ **MILTON J. E. SENN, M.D., New Haven, Conn.**

Sterling Professor of Pediatrics and Psychiatry, Yale University, and Director, Yale University Child Study Center

THE VALUE OF THE CHILD GUIDANCE CLINIC TO THE PRACTICING PHYSICIAN: Round Table, Thursday, Oct. 8

WHAT THE FAMILY PHYSICIAN SHOULD KNOW ABOUT EMOTIONAL PROBLEMS OF CHILDREN: Thursday, Oct. 8

(Closing General Session)

■ ■ ■

■ **PAUL L. SHALLENBERGER, M.D., Sayre, Pa.**

Clinical Professor of Medicine, Hahnemann Medical School, Philadelphia, Pa.

LESIONS OF THE LOWER COLON: Tuesday p.m., Oct. 6

PEPTIC ULCER: Round Table, Wednesday, Oct. 7

■ **WILLIAM M. TUTTLE, M.D., Detroit**

Associate Professor of Clinical Surgery, Wayne University

SURGICAL MANAGEMENT OF UNRESOLVED PNEUMONIA: Wednesday a.m., Oct. 7

(Sponsored by Wisconsin Anti-Tuberculosis Association)

DIAGNOSTIC DIFFICULTIES IN CARCINOMA OF THE LUNG: Round Table, Wednesday, Oct. 7

THORACIC TRAUMA: Wednesday p.m., Oct. 7

■ ■ ■

■ **LAWRENCE R. WHARTON, M.D., Baltimore**

Assistant Professor of Gynecology, Johns Hopkins University

UROLOGIC COMPLICATIONS IN OBSTETRICS AND GYNECOLOGY: Wednesday a.m., Oct. 7

NON-OPERATIVE TREATMENT OF STRESS INCONTINENCE IN WOMEN: Wednesday p.m., Oct. 7

■ ■ ■

■ **WILLIAM T. GREEN, M.D., Boston**

Clinical Professor of Orthopedics, Harvard Medical School

RECONSTRUCTIVE SURGERY IN POLIOMYELITIS: Tuesday a.m., Oct. 6

(Sponsored by National Foundation for Infantile Paralysis)

■ ■ ■

■ **JOSEPH H. HAFKENSCHIEL, M.D., Philadelphia**

Cardiovascular Section of the Hospital of the University of Pennsylvania

MEDICAL MANAGEMENT OF HYPERTENSION WITH PARTICULAR REFERENCE TO HYPERTENSIVE DRUGS: Wednesday a.m., Oct. 7

ETIOLOGICAL CONSIDERATIONS IN ARTERIAL HYPERTENSION AS DETERMINED BY THE SUCCESS OF CERTAIN MEDICAL OR SURGICAL PROCEDURES: Wednesday p.m., Oct. 7

Special Demonstrations and Scientific Exhibits:

Each day, from October 6 through 8, special teaching programs in these fields will be presented from 9:00–10.00 a.m.:

1. **OBSTETRICS & GYNECOLOGY: Movies and manikin demonstrations on special problems related to obstetrics and gynecology. Problems arranged by Wisconsin Society of Obstetrics and Gynecology.**
2. **FRACTURES: Proper application of casts and special technics to secure best results. Programs arranged by Wisconsin Society of Orthopedics.**
3. **CEREBRAL PALSIED CHILD: Demonstration with use of children of technics used to evaluate function and to improve movement. Programs planned by Wisconsin Association for the Disabled and the Milwaukee Cerebral Palsy Clinic.**
4. **GROSS PATHOLOGIC TISSUE: Every day demonstrations and lectures on significant pathology, by members of the Wisconsin Society of Pathology.**
5. **ANATOMIC DISSECTIONS: By Department of Anatomy, Marquette University Medical School. Emphasis will be on the position of the spinal needle in a lumbar puncture and the anatomic landmarks and hazards of a tracheotomy.**

Wisconsin Physicians on 1953 Annual Meeting Program

TUESDAY, OCT. 6

ANESTHESIA: INFANT RESUSCITATION: William Kreul, M.D., Racine

MEDICINE AND PSYCHIATRY: NEW DEVELOPMENTS IN ANTICOAGULANT THERAPY: John Hirschboeck, M.D., Milwaukee

ORTHOPEDICS: DISABILITY EVALUATION: Chester C. Schneider, M.D., Milwaukee

ROUND TABLE LEADERS FOR TUESDAY: Owen Clark, M.D., Oconomowoc; John Gonce, Jr., M.D., Madison; W. S. Middleton, M.D., Madison; F. J. Hofmeister, M.D., Milwaukee; J. L. Sims, M.D., Madison; James Conley, M.D., Milwaukee; Sture A. M. Johnson, M.D., Madison; John Curtis, M.D., Madison

WEDNESDAY, OCT 7

OBSTETRICS AND GYNECOLOGY: THE PRESENT DAY STATUS OF MYOMECTOMY: Joseph F. Egan, M.D., La Crosse

PATHOLOGY: THE MEDICOLEGAL ASPECTS OF SUDDEN DEATH: L. J. Van Hecke, M.D., Milwaukee

TUMORS IN CHILDHOOD: Gorton Ritchie, M.D., Milwaukee

ROUND TABLE LEADERS FOR WEDNESDAY: Ovid Meyer, M.D., Madison; Kenneth Winters, M.D., Wauwatosa; C. S. Rife, M.D., Milwaukee; A. C. Edwards, M.D., Racine; Leslie Osborn, M.D., Madison

THURSDAY, OCT. 8

OPHTHALMOLOGY AND OTOLARYNGOLOGY: RADICAL SURGERY IN THE TREATMENT OF ADVANCED CARCINOMA OF THE LARYNX: Charles J. Finn, M.D., Milwaukee

OCCLUSION OF THE CENTRAL RETINAL ARTERY: C. G. Kirchgeorg, M.D., Neenah

PEDIATRICS: PRESENT STATUS OF EPILEPSY: M. G. Peterman, M.D., Milwaukee

STATUS OF IMMUNE GLOBULIN: W. D. Stovall, M.D., Madison

RADIOLOGY: Case studies by Wisconsin radiologists will be listed in the complete program.

SURGERY: DIAPHRAGMATIC HERNIA: William P. Young, M.D., Madison

ROUND TABLE LEADERS FOR THURSDAY: Francis Murphy, M.D., Milwaukee; Silas Evans, M.D., Milwaukee; Thomas Leonard, M.D., Madison; John Schindler, M.D., Monroe; Fred Madison, M.D., Milwaukee; Frank Weeks, M.D., Ashland; Donald Ruch, M.D., Milwaukee; R. H. Quade, M.D., Neenah

Reminders . . .

GOLF: At North Hills Country Club, Monday, Oct. 5 (day before scientific sessions start). Register with Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee.

ANNUAL DINNER: Wednesday evening, Oct. 7, at Hotel Schroeder. An entirely different type of dinner. No long speeches . . . dancing during dinner and in late evening . . . professional entertainment following dinner. Because of "night club" setup, attendance must be limited. Your reservation blank will reach you on July 15, so watch for it.

SPECIAL ART SHOW: Tuesday, Oct. 6, in cooperation with Milwaukee Art Institute and the Woman's Auxiliary. Reception at Milwaukee Art Institute, followed by buffet dinner at Hotel Pfister, and then a light talk by internationally famous New York photographer and illustrator, Lejaren A. Hiller.

HOUSE OF DELEGATES: First session tentatively planned for Monday, Oct. 6, at 10:00 a.m.

MAKE YOUR RESERVATIONS AT THE HOTEL SCHROEDER EARLY, AS WE ANTICIPATE AN UNUSUALLY HEAVY REGISTRATION FOR THIS OUTSTANDING ANNUAL MEETING PROGRAM.

Scientific Highlights and Guest Speakers

Tuesday, Oct. 6th: SCIENTIFIC PROGRAMS . . . New! Different!

- Special programs in these fields during morning:

  ANESTHESIA (Regular meeting of Wisconsin Association of Anesthesiology):
  John W. Pender, M.D., Rochester, Minn.
  W. O. McQuiston, M.D., Peoria, Ill.

  MEDICINE AND PSYCHIATRY:
  Joseph Aub, M.D., Boston
  David Boyd, M.D., Rochester, Minn.

  ORTHOPEDICS:
  G. E. Haggart, M.D., Boston

- LUNCHEONS (Full schedule of scientific luncheons. Your notice will reach you on July 15.)

Wednesday, Oct. 7th: SCIENTIFIC PROGRAMS

- Special programs in these fields during morning:

  CARDIAC AND PULMONARY DISEASES:
  J. H. Hafkenschiel, M.D., Philadelphia
  C. K. Friedberg, M.D., New York
  W. M. Tuttle, M.D., Detroit

  OBSTETRICS AND GYNECOLOGY (Regular meeting of Wisconsin Association of Obstetrics and Gynecology):
  L. R. Wharton, M.D., Baltimore
  C. G. Collins, M.D., New Orleans

  PATHOLOGY (Regular meeting of Wisconsin Society of Pathologists):
  Brig. Gen. E. DeCoursey, M.D., Washington, D. C.

- LUNCHEONS (10 scientific luncheons and Marquette Alumni Association luncheon.)

Thursday, Oct. 8th: SCIENTIFIC PROGRAMS

- Special programs in these fields during morning:

  PEDIATRICS:
  O. P. Kimball, M.D., Cleveland
  Milton Senn, M.D., New Haven, Conn. (afternoon session)

  RADIOLOGY:
  Traian Leucutia, M.D., Detroit

  SURGERY:
  Robert M. Janes, M.D., Toronto
  J. Barrett, Brown, M.D., St. Louis

  OPHTHALMOLOGY AND OTOLARYNGOLOGY:
  O. J. Becker, M.D., Chicago
  H. M. Burian, M.D., Iowa City

- LUNCHEONS ("Full house" with many guest speakers as leaders.)

SEE JULY, AUG., AND SEPT. JOURNALS FOR DETAILS OF THESE OUTSTANDING PROGRAMS

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 JUNE 1953 Number 6

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Open Letter to American Medical Association

"A series of articles regarding 'fee splitting' is currently running in our newspapers and magazines, at the instance and under the direction of the American College of Surgeons (A.C.S.). These articles are very disturbing to many of our people, as well as to a large number of physicians. The principal reason for that, we believe, is that no one seems to come forward with a plain, explicit, authoritative definition of what is really meant by 'fee splitting.'

"The American Medical Association (the parent body to which practically all physicians belong) seems to have one interpretation; the American College of Surgeons another; the International College of Surgeons another; and so on and on. Before a greater number of our people become convinced that their physicians are 'suspect' as to ethical conduct, would it not be wise and fair for the A.M.A. to come forth boldly and bring this 'fee splitting' problem into proper focus; and not leave it to 'self-starting' organizations, no matter how worthy their motives, how noted their achievements, or how distinguished their membership?

"There are 18,000 members of the A.C.S. and there are 225,000 members of the A.M.A. By whose rules of ethics shall physicians be guided and governed—the A.M.A.—or the A.C.S.?—SPENCER D. BEEBE, M. D."—From the Milwaukee Journal and the Madison Capital Times, March 10, 1953.

The Ethics of Peeve Splitting

Dr. Spencer Beebe, Sparta, has written letters to the *Capital Times*, the Milwaukee *Journal*, and also the State Medical Society, stating his pet peeve about the publicity given to the utterance on fee splitting by Dr. Paul Hawley, secretary of the American College of Surgeons. We thought the problem had been solved basically in 1913, or thereabouts, when the American College of Surgeons and the American Medical Association, agreeing that it was unethical to split fees, made it part of their respective codes of ethics. About the same time, a state law making fee splitting illegal was enacted. Last year, in revamping its code of ethics, the American Medical Association again stated that fee splitting in any form was unethical because it was prejudicial to the best interests of patients.

Criticism of Doctor Hawley's articles on fee splitting probably stems from the fact that too much publicity is being given to a problem which is slowly being licked by the profession itself. It would be better if the discussion were confined to medical circles.

It seems to us that there are two points of argument presented. Number one has to do with fee

splitting itself: Is it illegal in any form whatsoever? According to all codes of ethics, in particular those of the American Medical Association, it is. Every hospital has rules against it and the State of Wisconsin has a law against it. No matter what high motives may have prompted Doctor Beebe or other physicians who continue this practice, the fact remains that the end result of fee splitting may be to induce or entice surgery on merits bearing no relation to skill or reputation. This is wrong.

The number two argument is purely a matter of public relations. Should our own profession be policed by giving publicity in lay publications to infractions of the code of ethics? Doctor Beebe says that he always has split fees and will continue to do so. Contrary to the great mass of medical opinion, he believes himself to be right. The merits of fee splitting have been fully and freely discussed in the House of Delegates of the State Medical Society and the American Medical Association. The profession's decision is clear cut. Continuing the controversy in the public press simply produces another brand of kickback.

The argument about improving or harming public relations by press discussion of this particular problem seems to work both ways. What's sauce for the goose is sauce for the gander!

Thanks, Mr. Editor

It is almost impossible to estimate the time that is taken from a doctor's practice by patients who wait until an "emergency" develops, when they could have called the doctor much earlier. That habit is hard on both physician and patient. Hats off to the Hartford editor who sees that some of the responsibility for good medical care belongs to the public.

The Hartford Times-Press

PUBLISHED EVERY THURSDAY

28 E. Jackson Street, Hartford, Wisconsin

Entered as second class matter Nov. 18, 1933, at the postoffice at Hartford, Wisconsin, under Act of March 3, 1879.

JOHN J. SHINNERS.....Publisher and Editor

Several times during the holidays just past, we had occasion to attend gatherings and parties at which one or another of our local doctors happened to be present. On almost every occasion, the MD was called to the phone at least once during his stay, sometimes several times, and a couple of times he was forced to leave and make a call. We have seen that same thing happen down through the years, and always the reaction is the same on the part of the people who see this happen—"What a job! Oh! for the life of a doctor!" and many other similar reactions. Yes, a small town doctors life is certainly a rugged one, but we often wonder if most of us couldn't be a little more helpful in trying to eliminate those completely thoughtless and unnecessary calls at odd hours. Many times, we have heard a doctor remark, "Gee, that thing has been going on for three days, and still, the urgent call comes at three in the morning, or during the evening when I am playing cards." The doctors are always available, no question about that, but many times this availability is abused. Let's try and be a little careful about those odd hour calls. After all, the doctors are only human, too.

. . . . The President's Page . . . .

Gamma Globulin—A Challenge to Cooperation

THE advent of gamma globulin for use in the prophylaxis of poliomyelitis presents a real challenge to the medical profession. Here is a situation in which scientific progress has produced a method of treatment heralded by the public press as a preventive for the much dreaded disease of polio. The public has been conditioned by many years of fund raising and health education campaigning to look at polio as being of alarming epidemic proportions even though the cases may be relatively few in number and the death rate far below that of other serious diseases. What is more, the supply of gamma globulin is definitely limited. The combination of these circumstances produces a public relations situation for medicine which requires the utmost cooperation of health organizations, individual physicians, and the public.

The Wisconsin State Board of Health and the Blood Bank Committee of the State Medical Society have been widely disseminating complete and detailed information concerning the allocation of gamma globulin to Wisconsin, the method of obtaining gamma globulin, and the persons for whom its use is recommended.

The State Board of Health will receive a basic allocation of about 51,000 cc. of gamma globulin for poliomyelitis prophylaxis. This represents about 7,300 average immunizing doses for children of 6 to 7 years of age. If used at random for children under 19 years of age during a severe epidemic, these 7,300 doses would probably not prevent more than 11 cases of poliomyelitis. It is obviously necessary that some limitations be established in order to prevent useless administration and to secure the best possible results.

Gamma globulin will be distributed only to physicians licensed to practice medicine in Wisconsin. There will be no charge for the gamma globulin. There will be no physicians who have exclusive rights in any area to the use of gamma globulin. Physicians may secure gamma globulin through the district offices of the State Board of Health, city health departments in Janesville, Kenosha, Madison, Milwaukee, Racine, Sheboygan, and West Allis, and the Bureau of Communicable Diseases of the State Board of Health in Madison.

Under the regulations established for its use, gamma globulin will be distributed for use in persons 19 years of age and under who reside in a household where a clinically diagnosed acute case has occurred. It is also distributed for use in pregnant women, regardless of age, who are also household contacts to acute cases.

The full details of the use of gamma globulin have been discussed in the April issue of The Wisconsin Medical Journal on pages 223 and 224 and in circular letters from the State Board of Health and the State Medical Society distributed throughout the state.

Physicians will do well to keep this material readily available for reference. The inclination to panic on the part of the general public in the use of gamma globulin during polio epidemics can be discouraged by effective doctor–patient relationships. The press of Wisconsin has been fully informed of these details and should be willing to cooperate completely with the profession in this regard. Members of the State Medical Society should grasp this situation firmly before polio cases, already on the increase, rise to the point of epidemic. Caution, understanding, and cooperation will be the key to the success of this program.

J. C. Griffith M.D.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Bulk Medicine

"Dr. Edward J. McCormick of Toledo, president-elect of the American Medical Association, considers the present time as propitious to present, especially to labor and management, a few of the facts of progress that have . . . accounted for the dismay and confusion among rabies, lockjaw, malaria, typhoid, pneumonia, mastoiditis and diphtheria, and in addition the great progress that is being made in the treatment of tuberculosis, polio and cancer and in infant care.

"Dr. McCormick drew a picture of what might be called lock-step medicine. He related how impossible it was to treat people always upon the same formula. The trouble is that people are not made the same way. One person can devour chocolate and thrive upon it. Another cannot eat it or he will break out in blotches. One antibiotic may be entirely curative to one person and cause all sorts of tumult in the body of another. Insulin works wonders in some cases of diabetes. In other cases it has to be watched constantly.

"'It makes no difference who the person is,' continued Dr. McCormick, 'he must be individualized' and he cannot be handed production-line treatment without risking his safety."—GREEN BAY PRESS-GAZETTE, May 2, 1953.

* * *

Rep. Bolton's Proposal

"The bill introduced in congress by Representative Oliver P. Bolton of Ohio strikes us as a good alternative to proposed medical care by the federal government. His bill provides that medical and dental expenses, including the cost of participation in voluntary medical insurance and hospital plans, may be deducted from income for federal income tax purposes.

"At present, all persons below 65 years of age may deduct medical bills only to the extent that they exceed 5 per cent of a person's gross income. Present law allows only persons over 65 to deduct all medical expenses.

"Health insurance coverage is being extended to more and more Americans, but many families find the cost of insurance a heavy financial burden. In many instances, too, policies do not cover the major cost of a prolonged and serious illness.

"The Wall Street Journal pointed out in a recent issue that the present law requires the taxpayer to pay taxes on his own efforts to maintain or better his health. Even business gets a better break from the tax law than this, for business can depreciate a building or a new piece of machinery.

"The Wisconsin State Journal puts the situation this way:

"'We can turn a lot more taxes over to Uncle Sam to care for our health, or Uncle Sam can let us keep some of our own money and thus make it easier for us to meet our own financial responsibilities and buy the type of medical treatment we prefer and can then afford.'"—ANTIGO JOURNAL, May 2, 1953.

* * *

Rural Medical Care

"A short time ago, the National Conference on Rural Health was held in Virginia . . . It drew more than 600 representatives of medical, agricultural, university extension services and other groups with a combined membership of several millions . . . The gist of the reports and statements made is that medical care facilities in rural areas are increasing rapidly through cooperative, voluntary efforts of medical, farm and community groups."—SHAWANO EVENING LEADER, April 8, 1953.

"Many people have felt that a main step in bettering rural medical care is simply to increase the number of doctors graduated by our medical schools . . . The president of the AMA said, 'A physician who has spent eight to thirteen years of his life in being trained to practice modern medicine is not willing to settle in an area where there are no facilities for practicing such a type of medicine.'

"He pointed out that in some states the problem has been solved by the community providing medical facilities and then permitting the doctor to rent or buy them . . The big point is that tremendous progress in solving rural medical care is being made by voluntary action. We don't need government to tell us how to do it—or to attempt to do it for us."—WAUKESHA FREEMAN, April 11, 1953.

Minutes of the Council Meeting, Madison, February 28—March 1, 1953

1. Call to Order

The Council was called to order by Chairman Arveson at 10:00 a.m., Saturday, February 28, at the Park Hotel, Madison.

2. Roll Call

Councilors present were Doctors Hemmingsen, Hill (Sunday), Dessloch, Heidner, Fox, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, and Chairman Emeritus Gavin (Sunday).

Also present were President Griffith; President-Elect Tenney; Speaker Forkin; Vice-Speaker Fons; Treasurer Weston; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association (Sunday); Dr. W. D. Stovall, AMA delegate; and Dr. C. D. Neidhold of Appleton.

Staff present were C. H. Crownhart, secretary; R. T. Ragatz, assistant secretary; R. J. Hoops, comptroller; R. B. Murphy, legal counsel; and Miss Joan Pyre and Miss Jean McGruer of the Society's office.

3. Approval of Minutes, October and November Meetings, 1952

The attention of the Council was directed to an omission in the minutes of its November meeting. At that time a special building planning committee, composed of Doctors Tenney, Hill, and Dessloch, was appointed tc direct and to expend funds for preliminary planning and choose an architect in connection with the new building.

With this correction in the November minutes, on motion of Doctors Dessloch–Heidner, carried, the minutes of the July meeting, as published in the November issue of *The Wisconsin Medical Journal*, and the minutes of the October and November meetings, as published in the December issue of *The Wisconsin Medical Journal*, were approved.

4. Report of the Interim Committee, January 1953 Meeting

a. Wisconsin State Dental Society

The Interim Committee has accepted an invitation of officers and other representatives of the Wisconsin State Dental Society to meet with them in March for discussion of mutual problems. Such a meeting, on an informal basis, was held in 1952. The Interim Committee will report any developments from the 1953 meeting.

b. Statements Unfavorable to Medicine

The Interim Committee received a communication from Dr. George Lull of the American Medical Association, directing attention of the Society to the fact that it is customary in some areas of the country for physicians to watch for statements unfavorable to medicine, such as sometimes appear in editorials and speeches. If the information is erroneous, local physicians endeavor to direct correct information to the person responsible. This action has in some instances resulted in public retraction.

The Interim Committee recommends to the Council that Doctor Lull's letter be published in *The Wisconsin Medical Journal* and that county medical societies be asked to carry out such procedure with the staff facilities of the State Medical Society available for assistance.

On motion of Doctors Heidner–Zellmer, carried, the recommendations of the Interim Committee were approved and the staff directed to carry them out.

c. IBM Membership Tabulations

With the acquisition of key punch mechanisms and other IBM machinery in the offices, it will be possible to maintain statistical information on physicians in Wisconsin to an extent not heretofore possible. Such a procedure can be carried on with the cooperation of the American Medical Association and annual statistical information may be compiled for later use.

Initial preparation of material necessary to maintain statistical studies will not be particularly expensive and the IBM mechanism actually should not involve much added cost to the Society, as it will replace manual time now necessary to provide such information.

The Interim Committee has authorized the secretary's office to proceed and it is planned to initiate this procedure January 1, 1954.

d. Dane County Medical Society

The Interim Committee has approved a cooperative effort undertaken with the Dane County Medical Society to have its clerical work in connection with membership done by the staff of the State Medical Society, with the Dane County Medical Society paying $50 a month for this service. This effort is on a "trial" basis and during the year it will be determined whether the monthly reimbursement from the Dane County Society will be sufficient to cover actual cost of time expended.

e. Wisconsin Public Health Council

The Interim Committee has authorized the staff to cooperate with the Wisconsin Public Health Council and a subcommittee of the Legislative Council of the Wisconsin legislature in connection with public health surveys which are soundly based and where there is an understanding of the difference between public health needs and wants.

f. Section on Medical History

The Interim Committee recommends adoption of the following resolution as an interim action of the Council, to be immediately effective and to be submitted to the House of Delegates for ratification:

WHEREAS, the Council of the State Medical Society has expressed interest in the development of a special voluntary membership classification of the State Society for the purpose of supervising and directing programs and projects in the field of medical history,

Therefore be it resolved, that the following amendment to the By-Laws of the State Medical Society be approved by the Council and submitted to the House of Delegates for approval at its first meeting. This By-Law shall be numbered Section XII, with subsequent sections numbered accordingly.

Section on Medical History

Section XII. Membership in this section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

It is further recommended that the Historical Committee of the State Medical Society be requested to initiate organization of the Section on Medical History and to get a program under way immediately.

On motion of Doctors Dessloch–Zellmer, carried, the recommendations of the Interim Committee were accepted, and the By-Laws amended to include the Section on Medical History, such amendment to be submitted to the House of Delegates, at its next meeting, for ratification.

g. American Medical Association Dues

Beginning in 1950, the AMA remitted to the various state medical societies 1 per cent of AMA dues collected by the state societies. In Wisconsin, this amounts to about $625 annually. Prior action of the Council was to the effect that this remittance should be distributed to the county medical societies based on the dues collected by each of them. The secretary advises that this has not been done as yet, because it will require a great deal of time and the staff has not had time available to make these computations.

The Interim Committee recommends to the Council that its prior action be rescinded.

The action of the Council taken at its February 1951 meeting to distribute the amount paid for collection of American Medical Association dues, amounting to 1 per cent of each collection, was rescinded, on motion of Doctors Ekblad–Dessloch.

h. Citizenship Requirements for Membership

Under the laws relating to licensure of physicians in Wisconsin, citizenship is not required, but first citizenship papers must have been secured. Under provisions of Chapter XI, Section 3, of the By-Laws, citizenship is a requirement for membership in the State Medical Society.

The Interim Committee recommends to the Council that it forward to the House of Delegates a proposal to require only licensure in Wisconsin as a condition of membership.

On motion of Doctors Galasinski–Dessloch, carried, the recommendation of the Interim Committee was approved for submission to the House of Delegates.

5. Interim Report of the Secretary

The secretary reported on the financial status of the Student Loan Fund of the State Medical Society and the American Medical Educational Foundation of the American Medical Association, pointing out that because of the small number of contributions made to the funds, it is proposed to send the field secretary into each county in an effort to re-solicit interest and funds.

A study of group malpractice insurance is to be undertaken by the Grievance Committee of the Society, and in a general review of its work and the number of cases taken up, Mr. Crownhart stated that its activities were particularly well suited to aid in the preparation of the report which will be submitted.

In a brief report on Wisconsin Physicians Service, the secretary said that Blue Shield is now fully integrated as an activity of the State Medical Society, and under its control and direction; further, that although claims have multiplied to a considerable extent, staff organization has been completed to the best of the division's financial ability.

Mr. Crownhart reminded the doctors of the responsibility of the medical profession to interest itself in legislation and said the problem of the current legislature is an interesting one, with more than 20 new faces, and a large number of bills being introduced. He stated that the chiropractors, the osteopaths, and limited licensees are making a concerted drive to broaden their fields of practice. As an example, he cited the amendment being sought by the chiropractors to require employers, under the Workmen's Compensation Act, to post a panel of physicians *and* a panel of "specialists." The secretary stated that if this and other chiropractic legislation is successful it may be advisable to con-

duct a thorough fact-finding investigation into chiropractic education, evaluate it, and report back two years hence.

6. Report of the Treasurer, F. L. Weston, M.D.

Dr. F. L. Weston, treasurer, presented the following tentative report for the year ended December 31, 1952, which was approved on motion of Doctors Galasinski–Heidner, carried:

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
TENTATIVE BALANCE SHEET
December 31, 1952

Assets		
Cash in Banks		
Treasurer's Account	$ 10,710.42	
Petty Cash Account	300.00	
Total		$ 11,010.42
Accounts Receivable		
Current Account—WPS	1,515.39	
Other	283.77	
Total		1,799.16
U. S. Government Bonds		24,115.63
Working Capital Advances		
Wisconsin Physicians Service	29,000.00	
Wisconsin Veterans Medical Service Agency	7,500.00	
Northwest Airlines, Inc.	425.00	
Total		36,925.00
Building and Equipment		
Land	32,990.22	
Building	31,969.00	
Building Improvements	17,100.23	
Furniture and Equipment	16,535.13	
Total	98,594.58	
Less: Accumulated Depreciation	12,543.84	
Total		86,050.74
Prepaid Insurance		285.53
Total Assets		$160,186.48
Liabilities and Reserves		
Vouchers Payable	$ 1,253.36	
Reserve for Dues	1,637.95	
Reserve for 1953 Advance Exhibit Space Rentals	4,387.00	
Reserve for 1953 Teaching Clinics Reservations	1,442.00	
Total Liabilities and Reserves		8,720.31
Net Worth		
Net Worth—January 1, 1952	$135,078.75	
Add: Excess of 1952 Income over Expenditures	16,387.42	
Net Worth, December 31, 1952		$151,466.17

PRE-CLOSING STATEMENT OF INCOME AND EXPENSES
For the period January 1, 1952, to December 31, 1952

Income		
Membership Dues		$165,244.18
Health Conferences		1,013.35
Medical Service Panels		151.00
Annual Meeting		16,311.75
Teaching Clinics		6,458.00
Prepaid Plans		5,890.70
Rental Income		17,520.00
Cafeteria		7,468.60
Interest Received		287.95
Miscellaneous		966.09
Total Income Carried Forward		$221,311.62
Total Income Brought Forward		$221,311.62
Expenses		
Central Office—Normal Operating	$ 41,834.29	
Public Health Information—Spec. Acct.	4,190.26	
Public Health Information—Press and Radio	6,061.36	
Medical Service—Open Panels	5,274.30	
Annual Meeting	17,163.24	
Teaching Clinics	8,521.32	
Wisconsin Medical Journal	4,200.00	
Veterans Agency and Prepaid Plans	4,302.98	
Interim and Special Appropriations	4,200.00	
Travel Accounts	7,173.34	
Group Insurance	838.75	
Employment Taxes	1,222.40	
Building	11,359.77	
Cafeteria	6,793.89	
Payroll—Executive Staff	39,593.36	
Payroll—Other	42,194.94	
Total Expense		204,924.20
Excess of Income over Expense		$ 16,387.42

7. Budget for 1953

The budget, as reviewed item by item and approved by the Council for the year 1953, follows:

Account	*Budget Item*	*Appropriation*
53	CENTRAL OFFICE NORMAL OPERATING EXPENSE (All salaries, employee travel, employment taxes, and group insurance are included in the Payroll Account 59.03–59.06 inclusive.)	
531	*President's Travel and Reimbursement*	$750
532	*Council, Officers, Delegates, and Committee Meeting Expense*—In 1951 this appropriation involved the expenditure of about $16,000 because of the different locations of the AMA meetings. With the elimination of certain committee activities, including the special fee committee, it was felt that the appropriation for 1952 could be reduced to $12,000. Actual expenditures were $11,000. In 1953 and in 1954, larger meetings will have to be held outside Society headquarters. Since this will increase their expense, the increased appropriation is recommended.	12,500
533	*Association and Dues Expense, State and National Organizations*—The Society holds membership in or supports the following organizations, including membership in clubs both in Madison and Milwaukee.	
	North Central Conference (State Medical Associations of Wisconsin, Minnesota, the two Dakotas, Nebraska, and Iowa	$100
	National Society for Medical Research—animal experimentation	50
	Wisconsin Public Health Council	100
	Conference of Officials of State and County Medical Societies	50
	Better Business Bureau of Milwaukee	50
	Associated State Postgraduate Committee	25
	World Medical Association, club membership, American and state hospital associations, State Chamber of Commerce, etc., approximately	300 675

Account	Budget Item	Appropriation
534	*Resource and Informational Material*—Various pamphlets and other publications are purchased and supplied to officers, councilors, and various members of committees, relating to a specific activity or responsibility. This is a varying procedure, depending upon new material issued and the need.	750
535	*Woman's Auxiliary to the State Medical Society*—For many years, in addition to assisting the Auxiliary in the program of the Annual Meeting ($500 annually), a nominal appropriation has been provided to reimburse stenographic, mailing, and other expense. Because of intensified efforts involved in the problem of health insurance and education, the Auxiliary has been called on for increased activity, both by its membership and other women's organizations. In 1951, it was felt that a reasonable sum should be provided the president and president-elect for their travel expenses. This appropriation also covers the expense of printing and mailing the quarterly bulletin of the Auxiliary. Note that secretarial assistance is separately treated in the payroll budget.	1,200
536	*Accounting and Insurance*—In 1952 the bookkeeping methods of the Society were completely revised from the system established in the early 20's. Although the new system is more complicated, the amount expended in 1952 does not reflect the cost of auditing for that year. In 1953 the figures will reflect the 1952 cost of auditing.	3,000
537	*Rent*—Total rent for the building was calculated at $17,500 for 1952. The acquisition of the lake shore lot and other expenses, including reallocation of space, improvements, and lighting, make it prudent that rent be calculated at slightly more than $20,000 annually, and that the monthly rent should, therefore, be $1,700. The total of $1,700 should be divided as follows: State Medical Society $640 Veterans Agency ($16 less than in 1952) 195 Wisconsin Physicians Service 825 Wisconsin Medical Journal 40	7,680
538	*Telephone and Telegraph*—Line cost is paid from the building funds so that each department shares the cost of the lines and the switchboard according to the number of extensions on the various desks. This appropriation carries the cost of long distance calls and telegrams.	2,000
539	*Office Supplies*—It is not possible to reduce this appropriation, which carries the cost of mimeograph paper, typewriter ribbons, stencils, and miscellaneous office supplies, the cost of which has increased substantially in recent years.	4,000
5310	*Postage and Printing*—This account carries the cost of printing membership certificates, membership cards, letterheads, mailing expense, and other items. It does not include cost of mailing the Medical Journal, which is paid through the Journal account itself.	3,600
5311	*Upkeep and Fixtures*—This account is chiefly one of maintenance. For example, the addressograph handles 225,000 and sometimes considerably more mailings each year. In addition, the robotyper, the mimeograph machine, typewriters, adding machines, and other office equipment must be maintained. The account also carries the cost of maintaining the addressograph plates, of which there are approximately 5,000 in current use, 3,600 for membership distribution, including the Wisconsin Medical Journal, addressograph plates for separate runs to councilors, officers, High Lights letters, and others, so that manual addressing time will not be necessary on these letters. Approximately 1,400 plates are used in connection with Auxiliary mailings. The frame and plate cost about 6 cents each. Each individual address plate involves about 3 cents. It will interest the councilors and officers that approximately 1,500 addresses or damaged plates are changed annually.	1,200
5312	*New Equipment*	3,000
5318	*Legal*—Our attorneys are frequently contacted directly by doctors and others for advice, and these requests are always cleared with the office before being fulfilled. However, when such requests are made by various state groups, they cannot be ignored. In addition, the attorneys advise the individual officers on their activities in behalf of the Society and attend all meetings of the Council and certain of the major committees and the like. Many of these are treated without billing, inasmuch as the appropriation amounts in part to a type of retainer.	3,400
5319	*General Bulletins to Members*—Each year requires at least three, and sometimes four, special bulletins to members on some unusual problem. The account carries the biannual reports of the delegates to the AMA. It is for printing only and does not include postage.	600
5320	*Blue Book Issue, Special Appropriation*—The permanent issue of the Blue Book will be completely revised in 1955. The 1949 edition is obsolete in some respects and, in any event, the supply is virtually exhausted. The cost cannot be determined at this date, but it will not be less than $5,000. The supply printed in that year should suffice for another 5 years.	2,500
5325	*Miscellaneous*—This is an overflow account for items which the staff does not anticipate or which it would not be logical to assign to any of the preceding accounts.	1,000

Account	Budget Item	Appropriation
54	PUBLIC HEALTH INFORMATION, SPECIAL ACTIVITY	
541	*Today's Health*—This is sent to elected public officials and others who have special interest in public health matters. The circulation amounts to approximately 270, and the expressions of appreciation are obviously sincere.	400
542	*Lay Publications*—This is to cover the cost of furnishing health studies, various health reports, including surveys of physician distribution, and public health procedures to those passing on various public health proposals.	300
543	*Special Bulletins*—This account is budgeted on an annual basis. It covers the cost of special bulletins dealing with proposed changes in laws affecting various public health problems. Usually, any unexpended balance reverts to the general account at the end of each two years.	850
544	*Wisconsin Medical Journal Special Inserts*—During many legislative years, special inserts are printed in the Wisconsin Medical Journal. This appropriation is budgeted annually and paid in a lump sum to the Wisconsin Medical Journal account, where it has been fully utilized, inasmuch as the Journal also carries a considerable amount of information concerning activities in other states and nationally.	600
545	*Special Telephone and Telegraph*—This is also an account used only biennially but budgeted annually. Unexpended balances in the odd year may be lapsed.	400
546	*Legislative Counsel*—This retainer is paid annually for services rendered chiefly during the legislative session, although interim studies of the legislature, as well as of the State Medical Society, also command a considerable amount of the time of the legislative counsel. It is important to note that the position of the Society is such that its advice on public health legislation is sought on many occasions. During 1952 a staff member has worked on a special legislative study with reference to the care of the aged. The amount of time required of legislative counsel during the actual session amounts to more than full-time service of one man for a six months' period.	3,600
55	PUBLIC HEALTH INFORMATION, PRESS AND RADIO	
551	*Press Releases*—Each year requires the preparation of special releases relating to various positions taken by the medical profession, special activities of the Medical Society, such as the Annual Meeting, and information to the press about the content of the Wisconsin Medical Journal, particularly that dealing with medical-economic matters. The Wisconsin Press Association handles the distribution of such releases through a special arrangement.	400
552	*Health Conferences, Exhibits, and Publications*—The Society sponsored a series of Rural Health Conferences in 1952, for the third consecutive year. In addition, the Society meets requests for exhibits, such as those provided for the Wisconsin Farm and Home Week, the annual meeting of the Farm Bureau; and such conferences as those related to press and radio problems. A special allotment of $200 from this account supports the health activities among the local 4-H clubs through the state 4-H Club office. A state School Health Conference, held in the fall of 1952, was sponsored jointly with the State Board of Health, the Department of Public Instruction, Public Health Association, School Health Council, PTA, and several other interested organizations.	2,000
5530	*March of Medicine, Recording*—The March of Medicine is carried weekly on 34 radio stations, including six on the WHA FM network (the state station in Madison).	1,200
5531	*March of Medicine, Supplies*—This account provides a moderate appropriation for replacing tapes, providing mailing cases, and other miscellaneous items. Also included is a sum sufficient for dictating and mimeograph supplies. The program produces "fan mail" varying from 200 to 600 letters a month, with a noticeable slack in the summer months. These inquiries are personally answered by Doctor Parkin with transcription in the office.	750
5532	*March of Medicine, Printing and Postage*—Health spot announcements are now available to the 71 Wisconsin stations, together with several radio stations in areas bordering on Wisconsin. These are circulated semimonthly, and the response from the radio stations has been excellent. The account also carries postage of 34 cents per tape, and similar items.	750
554	*Miscellaneous*—This account is for miscellaneous items in the five preceding accounts.	300
56	MEDICAL SERVICE, OPEN PANELS	
	This classification relates only to the preparation and distribution of approximately 85,000 panels provided biennially for posting in plants and other establishments subject to the Workmen's Compensation Act. The project, while carried out in alternate years, requires continuing activity. Amounts are not lapsed but are treated as a revolving appropriation. Panels are prepared on a county basis and reprints are available in bound volumes to various insurance companies and other organizations desiring them. The income from reprints recovers about $500 of the total expense incurred by the Society.	

Account	Budget Item	Appropriation
561	*Applications and Correspondence*—Members newly enrolled in the Society are circularized as to their desire to be placed on the panel, and in the preparation of the panel itself, all physicians must be contacted for verification of address, telephone numbers, listing under the two specialties available (eye, ear, nose, and throat; or eye only). New members sometimes request communications to plants within their areas, advising that their names have been approved for panel listing and will be included on the new panel.	250
562	*Panel Printing*—In 1952–53 this involves the printing of about 85,000 panels county-by-county and 100 bound copies. 123,000 form letters are circulated, one series signed by the Industrial Commission and the other by the State Medical Society.	2,000
563	*Envelopes*—This covers the purchase of envelopes for panel distribution.	350
564	*Postage and Addressing Costs*—All panel addressing must be by hand and requires the checking of individual records. Labor, utilizing part-time assistance, runs in the neighborhood of $900. Postage amounts to approximately $100.	1,000
565	*Miscellaneous Expense.*	200
57	ANNUAL MEETING The Annual Meeting involves 20 separate accounts, and a separate financial report relative to it is distributed to councilors and officers. The Annual Meeting expenses are handled as a revolving account with income from exhibits, luncheons, and miscellaneous items, including the Annual Dinner, turned back to the cost of the meeting. In addition, budgetary allotment is required. The total cost of the Annual Meeting in 1952 was $17,500, and income met $16,500 of the total expense. Expenses for the House of Delegates, including the stenotype report and the delegates' handbook, are $1,200. Other major items include the President's Reception, underwriting of the costs of scientific exhibits, speakers, and guests.	2,000
58	TEACHING CLINICS, INDUSTRIAL HEALTH CLINICS, AND COUNCILOR DISTRICT MEETINGS Total appropriation for these three budget items in 1952 was $4,850. Substantial assistance (about $4,200) was received from other sources. The teaching clinics are planned on an academic year, and it is difficult to produce a cost accounting until the whole program is completed.	
581	*Teaching Clinics, General*—This includes the circuit teaching programs (nine individual meetings for three circuits) and any special meetings. While registration fees are charged, these do not recover the expense of the clinics, which involves speaker honoraria, printing and postage, speaker meals, and hotel. Salary and staff travel are not allocated. The State Board of Health, the American Cancer Society, the Wisconsin Heart Association, and the Wisconsin Anti-Tuberculosis Association each participate financially to support certain phases of the clinics.	2,000
582	*Industrial Health Clinics*—The Industrial Hygiene Unit of the State Board of Health gives financial assistance by partially underwriting the printing and postage expenditures and contributing the major part of the reimbursement to speakers. The Society, other than staff assignment, pays for promotional expenses and speaker travel.	500
583	*Councilor District Meetings*—Small amounts are involved for postage and addressing of envelopes. Because of speaker selection, it is possible in some of the programs to have other agencies pay the honoraria and travel expenses. In some district meetings, such as the Third District, the program continues over the dinner hour, and the registrants pay a sum sufficient to cover their own dinner expense. This is also a revolving account in which the budget appropriation does not represent the entire income. Five councilor district meetings were held during the past fiscal year—Third, Fifth, Sixth, Tenth, and Eleventh. Speakers were secured and traveling expenses paid, on several occasions through assisting agencies.	500
59	WISCONSIN MEDICAL JOURNAL The Wisconsin Medical Journal is sent to each member of the Society and to subscribers, advertisers, medical societies, and others to a total of approximately 3,600. In 1951, gratis distribution was authorized to senior medical students of the two medical schools in Wisconsin. This involves an additional circulation of 160 and thus additional cost of printing and postage. A special type of addressing system has been established for this latter distribution, and, of course, it is completely revised each year. In addition, new members of the Society are furnished with the permanent Blue Book and the January supplementary issue, as are junior medical students. Some extra expense has been imposed upon the Journal because special pages have been made available to the clinical pathologists, the anesthesiologists, the State Board of Health, and others. The Journal is the official publication of the Society and under the Constitution and By-Laws is required to carry certain official reports and notices, such as minutes of the House of Delegates.	

Account	Budget Item	Appropriation
	Advertising rates for the Journal are studied annually and are pretty much in line with other state medical journals of comparable size and circulation. Practically all advertising is obtained through the State Journal Advertising Bureau maintained in AMA headquarters by participating journals of most state medical organizations. Advertising policies of the Journal are in conformity with advertising policies of the AMA, although some further restrictions have been imposed.	
	This again is a revolving account. None of the salary of the secretary or assistant secretary is assigned to the Journal. One full-time employee acts as assistant editor, and the salary of that employee is carried from the Journal account. Printing costs have advanced almost 40 per cent in the past several years. Because advertising contracts and rates must be established as much as 18 months in advance, the business management of the Journal is difficult with so limited a circulation and advertising appeal. At times the problems are wholly unpredictable.	4,200
5901	VETERANS AGENCY AND PREPAID PLANS	
	This budgetary item has been generally reorganized in order to present as clear a picture as possible of the character of Society expenditures from the dues account and the necessity for them, inasmuch as the programs necessitate expenditures on the part of the Society which on an accounting basis cannot be justifiably allocated to the program itself.	
	Activities of the AMA, the State Society, and other groups in the prepayment field, urging the extension of voluntary insurance, develop many problems and questions within the office, other than administration of the programs as they now exist. In some areas, special studies and other efforts have been necessitated by local problems. It continues the secretary's request, initially made in 1946, that none of his salary be allocated to any of these accounts, because he is the Society's employee as to all matters within its jurisdiction. He feels that no person occupying the position of secretary should be subject to possible influence in the disposition of problems of the Society by financial considerations personal to himself. The secretary does not object to, but on the contrary favors, salary allocations of other employees where such individuals actually work with problems relating to the two agencies.	
59011	*Wisconsin Physicians Service*—It is unnecessary to make allocation to this account in 1953. In the past it has carried items, relatively minor in individual amount and in which accounting procedures would be too intricate to be worth while, such as the share of the cost of the physician enrollment blank which is developed for all four activities in the Society, including the Wisconsin Plan, Veterans Medical Service Agency, Open Panel, and miscellaneous.	----
59012	*Wisconsin Plan*—In development of the Wisconsin Plan there have been annual preparation and printing of panels of participating physicians made available to people generally interested in the program and on a cost basis to participating insurance carriers and the like. Other expense includes stationery and printing of the Questions and Answers pamphlet. A workable system to recover those charges that are legitimately attributable to reviewing Wisconsin Plan problems, such as claims, policy forms, claim forms, and similar material, has now been worked out. The cost is paid by the participating companies.	5,000
59013	*Experimental Programs*—The Price–Taylor program has been discontinued. There is a carry-over for "wind-up" purposes.	----
59014	*Veterans Medical Service Agency*—The normal annual expense which requires Society underwriting approximates $1,000. Under the contract with the Veterans Administration and the policy of the general accounting office, committee, travel, and meeting expenses, as well as a few other items, are nonrecoverable. An effort was made in 1951 to reduce the expenditures by about one third. Since it proved unsuccessful, the recommendation is for restoration of the amount provided in prior years. See account number 59022 for a special report and recommendation.	1,000
59015	*Actuarial Expense*—It will be recalled that a substantial appropriation, provided as an interim appropriation, was made available for having the advice of an actuary on the Society's activities in prepaid insurance. The original appropriation (1950) was $5,000. No appropriation seems necessary in 1953.	----
5902	INTERIM AND SPECIAL APPROPRIATIONS	
	This account carries appropriations authorized subsequent to the annual session of the Council and miscellaneous appropriations believed to be of non-recurring nature.	
59021	*Student Loan Fund*—While active solicitation to implement this account has been instituted, it appears necessary that the State Medical Society support it from dues structure until such time as the fund has accumulated a sufficient amount to get into actual operation. Contributions total $11,310 to date of the preparation of this budget.	1,000

Account	Budget Item	Appropriation
59022	*Veterans Medical Service Agency*—By formal action, the Society has guaranteed that the administrative expenses of this agency will not exceed 12 per cent of total authorizations received from the Veterans Administration. The 1952 budgeted amount, not used, should be carried over.	----
59023	*State Historical Society, Survey of Medical Records and History.*	----
5903	TRAVEL ACCOUNTS	
59031	*Secretary's Travel*—Several trips are necessary for attendance at Blue Shield national and district functions. The cost of these trips will be charged into Blue Shield expense.	3,000
59032	*Assistant Secretary's Travel*—All travel of the assistant secretary, although related to certain specific activities, such as the circuit continuation courses, health conferences, etc., is charged into this account.	1,100
59033	*Director of Public Information Travel*	600
59034	*Field Secretary Travel*	1,200
59035	*Claims Manager and SMS Consultant Travel*	250
59036	*Medical Adviser Travel* (For radio activity)	150
59037	*Miscellaneous Travel* Various individual staff members are directed to attend some particular meeting in which it is more logical that they be present than others outlined in the budget; for example, sending the manager of the statistical division to a national Blue Shield–Blue Cross meeting involving workshop operations.	250
5904–5	EMPLOYEE TAXES AND INSURANCE	
5904	*Group Insurance*—This appropriation covers the contribution by the State Medical Society for employees eligible for Blue Shield and Blue Cross coverage based on contracts in effect January 1, 1953.	900
5905	*Employment Taxes — Social Security* taxes are computed at 1½ per cent of total payroll up to $3,600 on each individual. Wisconsin Unemployment Compensation tax is computed at 1 per cent of total payroll up to $3,000 on each individual. Federal Unemployment Compensation tax is computed at 3/10 per cent of total payroll up to $3,000 on each individual.	1,300
	Total	88,155
	Payroll as reported in payroll budget.	81,013
	Grand Total	$169,168

In the approval given the budget, it was understood that as in former years unexpended appropriations in certain accounts are treated as carryovers, and in detail they are (estimated) as follows:

Account	Budget Item	Appropriation
Account 543	Special Bulletins	$ 650
544	Wisconsin Medical Journal Special Inserts	600
545	Special Telephone and Telegraph	390
561	Applications and Correspondence	150
563	Envelopes	250
564	Postage and Addressing Costs	1,500
565	Miscellaneous Expense	100
583	Councilor District Meetings	500
59013	Experimental Programs	250
59022	Veterans Medical Service Agency	3,000
59023	State Historical Society, Survey of Medical Records and History	2,500
	Total	$ 9,890

Payroll Budget 1953

1.	Secretary salary	$20,000
2.	Assistant Secretary	10,725
3.	Claims Director of Prepaid Plans and Veterans Agency Director, allocation from budget (total annual salary $10,450)	1,800
4.	Director of Public Information, allocation from budget (total annual salary $8,100)	3,750
5.	Field Secretary, allocation from budget (total annual salary $6,600)	3,300
6.	Comptroller, allocation from budget (total annual salary $8,400)	4,200
7.	For four positions of executive assistant	14,402
8.	For four positions of administrative assistant	9,992
9.	For five secretaries	11,496
10.	For one clerk	1,348
		$81,013

8. Report of Interim Committee, February 27 Meeting

In its February 27, 1953, session, the Interim Committee considered a number of matters and reports the following for Council consideration:

a. Group Malpractice Study

In prior session the committee considered the matter of physicians' liability insurance and problems relating to its cost, increased difficulty of securing adequate protection, and similar matters. By direction of the House of Delegates, the staff is engaged in some study of this matter and has submitted a report concerning it. The Interim Committee favors staff recommendations that:

(1) The Grievance Committee be asked to conduct a detailed study, with a report back to the Council.

(2) The Grievance Committee be provided a budget, not to exceed $2,500, for this purpose.

On motion of Doctors Bell–Bernhart, carried, the above recommendations were approved, with the exception of changing the amount of the appropriation from $2,500 to $1,000.

b. Terms of Officers

The Interim Committee takes notice of the fact that at such time as the date of the Annual Meeting is advanced to May, officers elected the preceding October will have served a total of only 7 months. Recommending a provision that the terms of all officers should expire at the end of the calendar year was considered, but this does not seem wise.

The Interim Committee suggests to the Council that it report the situation to the House of Delegates and expressly note that the Council believes

no change in the Constitution and By-Laws is necessary, but the House should be advised so that there will be no later question on this point.

On motion of Doctors Fox–Galasinski, carried, it was directed that this recommendation be reported to the House of Delegates.

c. Conference on Children and Youth

The third Governor's Conference will be held in Madison the latter part of April 1953 and at the request of Governor Kohler, the State Medical Society will serve as one of the cooperating agencies, as it has in the past. This would involve a cost not to exceed $200, and the Interim Committee believes that the Society should continue its sponsorship. The Audit and Budget Committee has also approved the expenditure.

On motion of Doctors Hill–Fox, carried, the Council approved sponsorship of the conference and the expenditure of $200 for this purpose.

d. Code of Necropsy

The code of necropsy has been completed, was published in the January issue of the Wisconsin Medical Journal, and is in reprint form. Under it, a coordinating committee is created, with the State Medical Society designating a member. The Interim Committee recommends the appointment of Dr. Paul C. Dietz of La Crosse.

On motion of Doctors Heidner–Fox, carried, the recommendation of Doctor Dietz as a member of the coordinating committee was approved, and the staff was directed to so advise him.

e. Military Medical Service Committee

The Military Medical Service Committee has important functions in studying the availability of physicians and other matters relating to the physician and military service. To provide greater geographic representation on this committee, the Interim Committee recommends that it be increased from 5 to 7 members.

Approval of the Council was given to increase the membership of the Military Medical Service Committee on motion of Doctors Bernhart–Hill, carried.

f. Resolution of Wisconsin Society of Pathologists

A resolution of the Wisconsin Society of Pathologists respecting re-employment of its physician-members who have been called to military service was received in the office too late for consideration prior to the current meeting of the Council.

The Interim Committee believes that the resolution should receive careful consideration, that it not be taken up at this time, and that it should be placed on the agenda of the next meeting of the Council.

On motion of Doctors Zellmer–Kidder, carried, the resolution was laid over for action at the May Council meeting.

g. Report of the Committee on Blood Banks

The general blood procurement program is progressing satisfactorily, but there are many problems of great import to be solved in the near future. The Red Cross has the responsibility of securing more blood for gamma globulin in anticipation of the demand during the polio season, and distribution will be by the Office of Defense Mobilization, with state allocations directed to state health officers. The state health officer will need the closest cooperation of the medical profession to determine realistic and just methods of alloting gamma globulin on the basis of community demands within the state.

On the basis of its deliberations, the Committee on Blood Banks makes the following statements and recommendations:

(1) That it is essential that there be control in the distribution of gamma globulin, and that this control rest within the authority of the state health officer and the medical profession.

(2) That certain priorities in the use of gamma globulin be recognized, with primary concern directed to securing a sufficient amount of gamma globulin to meet all demands for protection against measles and hepatitis. Then, after this essential amount has been assured for this purpose, that the balance of the available supply be allocated to protection against poliomyelitis.

(3) That the public should be acquainted fully with the need for greatly increased supplies of blood to meet the anticipated demands in relation to poliomyelitis, but that it be made clear to all donors that the available supply of gamma globulin cannot be localized on the basis of donations, and that the individual who donates blood cannot have a personal priority for gamma globulin through his own donation of whole blood.

The American Red Cross and the medical profession have no control over the allocation of gamma globulin. A special allocating committee has been appointed by the Office of Defense Mobilization. However, it should be made clear to the public that unless they donate blood freely to this program, there will not be enough gamma globulin available even for the most necessary and urgent needs.

(4) That the State Medical Society recognize the need for close coordination between physicians and the state health officer, and give official advisory direction to the program of state distribution through authorization of the Committee on Blood Banks or some other official agency under the direction of the Council to serve as an advisory committee to the State Health Officer, and assist the Council in providing an official statement of policy to all physicians in Wisconsin.

Approval of the report was recommended by the Interim Committee and on motion of Doctors Hill–Dessloch, carried, the Council approved the findings of the Committee on Blood Banks and extended authorization requested to act in an advisory capacity to the State Health Officer.

9. Report of the Commission on Prepaid Plans

The following report of the Commission on Prepaid Plans was presented:

REPORT OF COMMISSION ON PREPAID PLANS

Fourth Quarter 1952

The Commission on Prepaid Plans is directed to report quarterly to the Council. This report covers the months of October, November, and December 1952.

New Sales and Conversions to New Program

Approximately 40 per cent of the total WPS groups had been converted to the new "A" and "B" schedules at the end of the year. Net growth for the quarter totaled 6,000 contracts.

Acceptance of the "A" schedule seems generally favorable. About one third of the contracts converted and new contracts sold through December 31 accepted "A" coverage. Ninety-nine per cent have purchased the 5 element contract.

In January 1952 the total contracts in force were 100,230, producing a total earned income of $193,000. Blue Cross was paid $19,000 in that month, with the total WPS administrative expense being $9,500.

By contrast, at the end of November 1952, contracts totaled 112,000. The total earned income was $254,600. Blue Cross was paid $26,850, and total WPS administrative expenses for that month were about $12,500.

Intraprofessional Relations

Conferences have been held with the employees of physicians in 22 communities. Attendance has totaled 300 individuals.

At these meetings there is a slide presentation of the contract and various forms associated with the plan, with particular emphasis upon the Physician's Service Report and the necessity of adequately describing services rendered. It is apparent that many physicians delegate much of this work, without any immediate supervision, and the education of their employees in the details of WPS should materially assist in carrying out the physicians' part in the program.

Advertising and Physician Relations

An advertising program was developed covering a period of three months, and costing Blue Cross, Surgical Care, and Wisconsin Physicians Service a total of $32,000. In addition to bringing in a substantial number of direct inquiries, the advertising program undoubtedly was of material value in effecting the change-over to date. The results did indicate needed changes in descriptive literature. In the ensuing year efforts will be made to provide a physician's manual and engage in a community enrollment program. About $10,000 is committed to a joint advertising campaign during the next six months.

Claims

Beginning July 1, 1952, as has previously been reported, claims were numbered for the purpose of the filing system as well as to maintain current inventories. Following are the totals by month, beginning with August. July is not reported because that represented an accumulation of numbers for claims received in that month and all prior claims that were still pending.

August	5,397
September	5,107
October	5,133
November	4,580
December	5,030

There has been no let-up in claim volume as there has been in previous years. Medical care is becoming a more prominent factor in processing of the new "A" and "B" contracts. Office procedures are being reported in increasing volume.

A new and simplified PSR has been approved by the Commission and should be available for physician distribution by spring of this year. These are multiple forms with copies provided for the physician's file, and require some months before delivery can be made.

It should be emphasized that claims administration is considerably more complex than under the old program. In handling every claim it is necessary to determine whether it is "A" or "B" coverage and whether it is the 4 or 5 element program. Claims are still coming in under the old program, but income levels are not involved, and the question of whether medical care was provided is simplified in the old plan by the elimination of all claims of less than three days' duration.

The Claims Committee has been confronted with a number of perplexing problems, among which is the determination of whether benefits should be paid in those cases where services are rendered just prior to completion of a waiting period—especially in maternity cases where services are rendered within 10 days prior to the expiration of the waiting period. The Claims Committee has established a rule that 10 days is a reasonable period of doubt, and the committee itself reviews those cases and in its judgment authorizes payment within this period. However, these cases are segregated for the purpose of determining the impact upon premium structure.

The policy of WPS in recognizing ectopic pregnancies as a matter of emergency surgery and excluded from the waiting period has finally been adopted by Blue Cross, which has issued a similar policy interpretation.

Financial Statements

Following are the WPS balance sheet and comparative operating statement through November. Books have not yet been closed for December.

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES

For the periods January 1 to November 30, 1951 and 1952

	1-1-1951 to 11-30-1951	1-1-1952 to 11-30-1952	Increase or (Decrease)
Income			
Earned Premium Income	$1,942,763.51	$2,366,893.11	$424,129.60
Investment Income	5,808.23	12,383.40	6,575.17
Total Income	$1,948,571.74	$2,379,276.51	$430,704.77
Expenditures			
Physicians Claims	$1,435,241.32	$1,891,037.65	$455,796.33
Expenses of Agent	175,163.39	233,874.03	58,710.64
Salaries	43,773.54	76,883.71	33,110.17
Legal Expense	4,970.55	8,057.49	3,086.94
Auditing Expense	5,127.22	9,177.19	4,049.97
Actuarial Expense	827.73	8,345.67	7,517.94
Conference Expense	3,594.66	8,988.86	5,394.20
Staff Travel	1,875.54	2,120.15	244.61
Stationery and Supplies	3,996.43	8,150.85	4,154.42
IBM Expenses		1,727.90	1,727.90
Rent	3,352.25	6,237.00	2,884.75
Office Expenses	1,438.35	2,127.35	689.00
Postage and Express	3,184.01	3,860.19	676.18
Payroll Taxes	1,204.18	1,779.32	575.14
Telephone and Telegraph	3,277.95	5,165.84	1,887.89
Employees Group Insurance	609.60	1,015.40	405.80
Depreciation	895.57	1,404.18	508.61
Insurance	380.22	388.75	8.53
Association Dues	2,475.28	2,826.09	350.81
Other Administrative Expenses	46.02	599.79	553.77
Total Expenditures	$1,691,433.81	$2,273,767.41	$582,333.60
Available for Reserves	$ 257,137.93	$ 105,509.10	($151,628.83)
Disposition of Income Dollar			
Physicians Claims	$ .74	$ .80	$ .06
Expenses of Agent	.09	.10	.01
Other Administrative Expenses	.04	.06	.02
Addition to Service Benefit Reserves	.08	.02	(.06)
Addition to Administrative Reserve	.05	.02	(.03)
Addition to Investment Res.			
	$ 1.00	$ 1.00	$

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

BALANCE SHEET
November 30, 1952

Assets		
Cash on Hand and in Banks		$ 496,354.45
Cash on Deposit with Agent		121,000.00
Due from Agent		131,595.02
Refunds Receivable		1,683.00
U. S. Government Bonds—Net	$797,884.00	
Accrued Interest Income	4,450.02	802,334.02
Office Furniture and Fixtures—Net		14,416.32
Unexpired Insurance		339.97
Other Deferred Expense		857.71
Total Assets		$1,568,580.49
Liabilities and Reserves		
Accounts Payable		$ 2,657.79
Accrued Expenses		20,697.96
Physicians Claims Payable		415,543.78
Unearned Income		269,729.55
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—Maternity Benefits	$167,500.00	
Disaster Claims	133,918.00	
Unforeseen Contingencies	304,588.11	
Administrative	204,958.00	
Investment	19,987.30	830,951.41
Total Liabilities and Reserves		$1,568,580.49

Statistics

Three units of IBM equipment are now installed and by early fall the balance will be available, so that all working processes of WPS adaptable to this type of mechanism will be fully under way by that time.

Cards are punched for the purpose of indicating claims paid, amount, to whom, and for what service. Separate statistical information is necessary for each of the large groups on which experience rating has been installed. Payments to participating physicians are through the IBM mechanism and total payments for each month of the last quarter in 1952 follow:

	Amount	*Procedures*
October	$126,261	4,137
November	140,801	4,426
December	161,477	4,856

Payments direct to subscribers (those who do not receive services from a participating physician) are individually prepared and for each month of the last quarter in 1952 were as follows:

October	$ 29,812	959
November	45,248	1,330
December	39,336	1,169

For the period January 1 to November 30, 1951, total payment for services rendered was $1,435,000. For the same period in 1952, total payment was $1,890,000.

Other Programs

Other matters within the jurisdiction of the Commission involve the Wisconsin Plan and the Wisconsin Interscholastic Athletic Association accident benefit program. This report does not discuss either of these in detail, as current studies and conferences are now under way; both matters will be discussed in a subsequent report of the Commission.

10. Report of House Planning Committee

The committee, consisting of Drs. H. Kent Tenney, N. A. Hill, and E. M. Dessloch, offered the following recommendations to the Council of the State Medical Society with reference to development of its building program:

a. The designation of Allen J. Strang, Madison, as the Society's architect.
On motion of Doctors Wegmann–Kidder, carried, designation of Mr. Strang as the architect was approved by the Council.

b. The committee recommends that it have the authority to negotiate termination of a 9-foot right-of-way in the property being acquired, either by purchase or by other agreement.
The Planning Committee was given broad authority to handle such technical details as appear necessary or desirable in connection with the property, on motion of Doctors Zellmer–Bell, carried.

c. The property and building, to be effectively managed, to assure proper financing and for other reasons, should be held by a realty corporation under the control and direction of the State Medical Society through its councilors and officers. The committee asks authority to organize such a corporation, of tax exempt character.

On motion of Doctors Ekblad–Hemmingsen, carried, authority was given the committee to organize the realty corporation.

11. Salary of State Health Officer

The salary of the state health officer had been considered previously by the Society's Committee on Public Policy and the Interim Committee, and it was pointed out that in the event of a vacancy in this office, it could not possibly be filled by a qualified man at the present salary level thus far established by the legislature. It has therefore been recommended that a determined effort be made to secure a salary in keeping with the responsibility and position commanded by the state health officer.

The staff was directed to send a special report to the councilors and officers of the Society, and on motion of Doctor Ekblad, variously seconded and carried, the staff was further directed to make appropriate efforts on behalf of the councilors and officers of the State Medical Society to secure an adequate salary increase in this position.

12. Elections

a. Chairman of the Council—Doctor Griffith assumed the chair for this order of business. On motion of Doctors Heidner–Ekblad, carried, Doctor Arveson was re-elected chairman of the Council for the ensuing year.

b. Treasurer—On motion of Doctors Bernhart–Hemmingsen, carried, Doctor Weston was re-elected treasurer of the Society for the ensuing year.

c. Secretary—On motion of Doctors Galasinski–Kidder, carried, Mr. Crownhart was re-elected secretary of the Society for the ensuing year.

d. Editorial Directors—On motion of Doctors Ekblad–Hill, carried, Doctor Sullivan was re-elected editorial director of the Wisconsin Medical Journal for a one-year term.

e. Members of Interim Committee—On motion of Doctors Dessloch–Ekblad, carried, Dr. J. M. Bell was re-elected to the Interim Committee, for the term expiring in 1956.

13. Adjournment

The meeting adjourned at noon, Sunday, March 1, 1953.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

SUMMER CAMP SCHEDULED FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fifth season under the auspices of the Chicago Diabetes Association, Inc., from July 21, 1953 to August 10, 1953 at Holiday Home, Lake Geneva, Wis.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by the Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee for $150.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

Service Unit, Chicago Diabetes Association
110 South Dearborn Street
Chicago 3, Illinois

Limited capacity requires prompt application.

Excess neural stimulation over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

The Standard of Therapy in Peptic Ulcer

Banthīne® Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthīne is supplied in oral and parenteral dosage forms.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ESEARCH IN THE SERVICE OF MEDICINE SEARLE

COMMITTEE *Concentrates*

COMMITTEE ON CIVIL DEFENSE APRIL 29

MDs present: M. J. Musser (chairman), K. E. Lemmer, E. P. Ludwig, P. C. Dietz, C. K. Kincaid, C. N. Neupert, A. L. Van Duser.

Established procedure for distribution of civil defense manuals for the operation of mobile medical teams. Each county medical society will get a copy in addition to that received by members of teams. Adjutant General and Civil Defense Director Olson called for the training of 100 mobile medical teams to a full state of readiness by Jan. 1, 1954. Plans were outlined for instituting training procedures for team personnel. A periodic bulletin on civil defense will be sent to all county societies and civil defense medical team personnel.

COMMITTEE ON PUBLIC POLICY APRIL 30

MDs present: J. M. Sullivan (chairman), J. C. Griffith, H. Kent Tenney, J. R. Schroder, J. A. Enright.

The committee reviewed the status of current legislation and reaffirmed its previous position, approved by the Council, on the physical therapy bills and the proposals respecting revision of the Medical Practice Act . . . considered in detail Bill 498, S., of the State Board of Medical Examiners and directed the staff regarding its position on various points of the bill . . . took up and advised its position on bills concerning dangerous drugs, hospital licensing, salary of state health officer, temporary educational certificates, testimony of out-of-state physicians, an advisory committee to study the problems of children, inspection of industrial camps, and a number of chiropractic proposals.

GRIEVANCE COMMITTEE MAY 2

MDs present: R. E. Fitzgerald (chairman), E. W. Mason, E. D. Sorenson, C. E. Zellmer, F. A. Nause, H. Kent Tenney.

HISTORICAL COMMITTEE MAY 3

MDs present: H. Kent Tenney (chairman), E. M. Dessloch, G. Kasten Tallmadge, P. R. Minahan, E. E. Kidder.

The committee met with Messrs. Clifford Lord and Don McNeil of the State Historical Committee, who discussed the State Medical Society Medical History project . . . elected W. D. Stovall chairman of the new Section on Medical History, P. R. Minahan vice chairman, Mr. Crownhart secretary-treasurer . . . referred to the officers a number of projects, including development of a work of medical history for long-time planning; periodic bulletins for profession and general public; exhibit and presentation at the Annual Meeting; and development of the Fort Crawford project.

COUNCIL ON MEDICAL SERVICE MAY 3

MDs present: D. E. Dorchester (chairman), R. L. MacCornack, D. N. Goldstein, D. M. Willison, J. S. Devitt, W. J. Fencil.

At the request of Dr. Frederick Bunkfeldt, Jr., of Milwaukee the Council approved support to the organization of a subcommittee on trauma in an effort to improve transportation and care of injured persons . . . discussed distribution of the first-aid charts prepared by the Society . . . approved a loan service to high schools of March of Medicine recordings . . . authorized joint sponsorship to proposed clinics on hearing loss in industry . . . authorized the chairman to appoint a special subcommittee to study the problems of nursing education in Wisconsin . . . discussed plans for National Rural Health Conference in Milwaukee, 1955 . . . recommended continuation of rural health conferences and press-radio conferences . . . proposed an accident survey in the

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

ACCIDENT • HOSPITAL • SICKNESS INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

state to further rural and home safety, and recommended continued support of 4-H Club activity in the health field by making available $100 to send delegates to the state 4-H Club health-safety planning conference.

RELATED ACTIVITIES

The chiropodists have been seeking a clarification of the statutes in reference to the type of surgery they can perform. They have complained that the law, as passed in 1949, actually eliminates any type of surgery they are permitted to do. They appeared before the Committee on Public Policy to present their case, and as a result a special committee of orthopedic surgeons was appointed to give further study to the problem. Drs. S. C. Rogers, Madison; Bruce Brewer, Milwaukee; and Charles Ihle, Eau Claire, were appointed to this special study committee. On May 6 a preliminary meeting was held with the chiropodists to see what changes might be presented to the Committee on Public Policy before the 1955 legislative session. Like so many problems, they did not seem insurmountable when presented in verbal conference instead of through correspondence. . . . The May circuit teaching program "played" to Delavan, Sheboygan, and Green Bay, with around 140 MDs in attendance. With the exception of two meetings in northern Wisconsin on June 24–25 this winds up the circuit programs for 1953. Next month, representatives of SMS, State Board of Health, Wisconsin Academy of General Practice, the two medical schools, and the voluntary health agencies will meet and decide what type of teaching programs will be offered in 1954. A preliminary evaluation suggests a possible curtailment, especially in the winter months.

INFORMATION FOR GOLFERS

The twenty-sixth annual golf tournament sponsored by the Medical Society of Milwaukee County for its members will be held Wednesday, July 15, at the Westmoor Country Club. Dr. Stanley Hollenbeck is chairman of the Golf and Entertainment Committee this year.

The St. Luke's Hospital team of Drs. S. E. Zawodny, F. J. Schubert, C. L. Budny, and J. G. Garland, is ready to take on any golf foursome of MD's, either at the tournament or any time during the season. Challengers should get in touch with Doctor Budny at St. Luke's, who guarantees a tough match on the basis of gross scores.

Speaking of golf, don't forget that the State Medical Society will hold its annual tournament on October 5, the day before the scientific programs at the Annual Meeting. Tee-off will be in the late morning or early afternoon at the North Hills Country Club, with dinner and awards that evening. Send your reservations to Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee.

UNIVERSITY OF ILLINOIS SCHEDULES ASSEMBLY IN OTOLARYNGOLOGY

The Department of Otolaryngology of the University of Illinois College of Medicine recently announced the dates for its Annual Assembly in Otolaryngology. The program is divided in two sections of five days each. Applications for attendance may be made for one section only or for both.

The Basic Section, September 21 through 26, is under the direction of Dr. M. F. Snitman. It will be devoted to surgical anatomy and cadaver dissection of the head and neck and histopathology of the ear, nose, and throat.

The Clinical Section, September 28 through October 3, will consist of lectures and panel discussions, with group participation on otolaryngological problems and current trends in medical and surgical management.

For information regarding registration write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

535 North Dearborn Street, Chicago 10, Illinois

ERICAN MEDICAL ASSOCIATION news notes JUNE 1953

AMA news written especially for use in state medical journals

Two Doctors Join AMA Hospital Field Staff

The recent appointment of Drs. Arthur N. Springall and Joseph J. A. McMullin boosts the field staff of the Council on Medical Education and Hospitals to nine full-time physicians. Each staff member has been assigned a geographic area and will review, on a biannual basis, the internship and residency programs in approved hospitals.

This increase in staff will expedite the processing of new applications for approval of internships and residencies and make possible a review of currently approved programs at least once every two years. At present the Council conducts the inspection program relating to the approval of hospitals for internship and residency training—a joint effort of the Specialty Boards, the American College of Physicians, and the American College of Surgeons. In addition, the professional staff will assume responsibility for surveys in behalf of the Joint Commission on Accreditation of Hospitals.

AMA Offers Two New Exhibits

Two new exhibits will be available for showing at state medical society meetings this fall, the Bureau of Exhibits reports. One exhibit—"Accidental Poisoning in Children"—is based on authentic fatal accident cases, while the other—"A Medical Service Program for Your Community"—covers various activities of medical societies and voluntary and public health agencies.

The exhibit on accidental poisonings, from the Committee on Pesticides, emphasizes points of danger in the home, yard, and selected farm locations. When staffed with trained personnel, this makes an effective showing at public gatherings, state and county fairs, and food and home shows. Subjects included in the exhibit developed by the Council on Medical Service range from care of the chronically ill to hospital construction, physician placement, and rehabilitation.

Both exhibits require space 10 feet long and six feet deep—or, if shown in extended fashion, 20 feet long and three feet deep. Requests for bookings may be made to the Bureau of Exhibits after June 15.

Add to Lists of Library and Films Cleared for TV

Supplementary lists of films cleared for television and films available through the AMA's motion picture library now may be obtained from the Committee on Medical Motion Pictures. One supplement lists 38 health education films cleared for TV since publication of the original list in 1951. The other includes 12 motion pictures added to the library since the December 1952 catalog was published.

AMA Survey on Hospital Service in U. S.

For the first time in history, hospital births topped the three million mark. The Council on Medical Education and Hospitals' 32nd presentation of hospital statistics reveals that in 1952 there were 3,170,495 hospital births, or one live baby born every 9.9 seconds. The report, which appears in the "Hospital Number" of the Journal of the AMA, May 9, shows a continued increase in the volume of hospital service in the United States.

Highlights of the report: 6,665 hospitals registered—with 18,914,847 admissions, compared with 18,237,118 the previous year. Bed capacity statistics show an increase of 11,627 over 1951. Average length of stay of individual patients in governmental general hospitals is more than twice as long as in nongovernmental general hospitals—16.4 days as compared with 7.5 days.

Data Available on County Society Activities

The third biannual survey of county medical society activities has been completed by the Council on Medical Service and is available on request. This year the survey covered a broader scope of activity in the field of medical service than previously, and results have been tabulated to show these activities by size of society. County societies may obtain, from the Council, general information on specific medical service programs and lists of societies where such programs already are in operation.

AMA Compiles Civil Defense Information

A complete bibliography of published literature dealing with the medical aspects of civil defense has been compiled by the Council on National Emergency Medical Service. This listing will be available on request from the Council after May 15.

Dramatic Medical Story to Be Related at SAMA Meeting

The story of the "Michigan Heart"—one of the outstanding scientific advances of 1952—will be unfolded by F. D. Dodrill, M.D., Detroit, head of the medical engineering team responsible for its development, during the Student American Medical Association's 1953 annual convention. The meeting will be held June 15–17 at Chicago's Edgewater Beach Hotel.

Other convention features include panels on the "doctor draft" and "general practice" . . . sessions of the House of Delegates . . . a large technical exhibit for the first time. Abbott Laboratories of North Chicago will sponsor the traditional opening day party while the American Medical Association will honor new SAMA officers with a reception on the last afternoon.

All physicians residing in or visiting Chicago are cordially invited to attend.

Society Proceedings

Barron–Washburn–Sawyer–Burnett

Dr. J. R. Patch of Duluth, Minnesota, was the guest speaker at the March 10 meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society. Meeting with members of the society at the Elks Club in Rice Lake, the doctor chose as the title of his address "Problems in Ear, Nose, and Throat Practice."

Calumet

The Calumet County Medical Society held a dinner meeting at Leon's Fine Foods, New Holstein, on Thursday evening, April 16. The guest speaker was *Dr. J. E. Kaufman* of Green Bay. The title of his talk was "The Intervertebral Disk Syndrome."

Fond du Lac

At a meeting at the Elks Club on April 23, members of the Fond du Lac County Medical Society heard an address by *Dr. F. E. Mohs* of Madison. Doctor Mohs, who is associated with the department of surgery at the University of Wisconsin, discussed "New Concepts in Prevention and Treatment of External Cancer." The program was arranged by *Drs. C. M. Flanagan* and *L. J. Keenan,* both of Fond du Lac.

Green Lake–Waushara

Dr. E. E. Kidder of Stevens Point, councilor of the Ninth District, was the special guest at the April 30 meeting of the Green Lake–Waushara County Medical Society. Meeting with the society at Peck's Plantation, Wautoma, the doctor led a discussion on recent legislation affecting the medical profession.

Kenosha

Thirty-nine members of the Kenosha County Medical Society heard an address by Mr. O. W. Gaarder of Madison at their May 7 meeting at the Elks Club. A representative of the Business Management Service, Madison, Mr. Gaarder's subject was physicians' incomes and investments and suggestions for the improvement of both.

Richland

Two Richland Center physicians, *Drs. R. E. Housner* and *D. J. Taft,* presented case reports at a meeting of the Richland County Medical Society on March 5 at the Pippin Clinic. Doctor Housner spoke on "A Case of Atelectasis in a Premature Newborn" and Doctor Taft on "A Case of Torsion of the Testicle in a 13 Year Old Boy."

Shawano

The April 15 meeting of the Shawano County Medical Society was held jointly with a Spring Clinic sponsored by the State Medical Society. This meeting celebrated the fiftieth anniversary of the founding of the Shawano Society. The program included talks by Drs. Herbert E. Schmitz, J. T. Reynolds, and Richard Langendorf, all of Chicago; and *Dr. Burton A. Waisbren* of Milwaukee.

Trempealeau–Jackson–Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met on April 14 at Wally's Hotel in Fountain City. *Dr. F. C. Skemp* was in charge of program arrangements.

When the society met at the Freeman Hotel in Black River Falls on May 12, three physicians from the Marshfield Clinic were the guest speakers. The speakers and their subjects were *Dr. F. J. Gouze,* cardiology; *Dr. N. J. Helland,* urology; and *Dr. J. J. Suits,* pediatrics.

Winnebago

A. J. QUICK, M.D.

Dr. Armand J. Quick of Milwaukee was the guest speaker at the May 7 meeting of the Winnebago County Medical Society, which was held at the Menasha Hotel. The subject of his talk was "The Diagnosis and Treatment of Hemorrhagic Diseases in General Practice."

Manitowoc Academy of Medicine

The recently organized Manitowoc Academy of Medicine held a dinner meeting at the Hotel Manitowoc on April 14. The guest speaker for the occasion was *Dr. Douglas A. Gutheil,* who is associated with the Maple Crest Sanatorium at Whitelaw. The doctor discussed "Pulmonary Tuberculosis."

Wisconsin Urological Society

Dr. Edward B. Jacobson, Milwaukee, was named president of the Wisconsin Urological Society when the group met at the Hotel Monterey in Janesville on April 25. *Dr. Harvey K. Guth* of Fond du Lac

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY-MANSFIELD DIVISION

is vice-president and *Dr. Earl F. Cummings*, Oshkosh, secretary-treasurer.

The first paper presented was "Primary Carcinoma of the Seminal Vesicle" by *Dr. G. H. Ewell*, Madison. Other morning speakers were *Dr. B. H. Brunkow*, Monroe, "The Use of Subcostal Incision in Renal Surgery"; *Dr. Kenneth Ghormley*, La-Crosse, "Testicular Tumors"; *Dr. Frank M. Hilpert*, Racine, "Plastic Repair of Hydronephrosis"; *Dr. Albert Graham*, Neenah, "Anuria"; *Dr. I. I. Kolman*, Milwaukee, "Torulosis of the Prostate"; and *Dr. Samuel A. Freitag*, Janesville, "Traumatic Rupture of the Urinary Bladder."

Three guests were the featured speakers during the afternoon portion of the program. Dr. W. J. Engle, Cleveland, Ohio, discussed "Renal Displacement"; Dr. C. D. Creevy, Minneapolis, Minn., talked on "Aortography in Urologic Diagnosis"; and "The Application of Desquamative Cytology to the Recognition of Tumors of the Genito-urinary Tract" was the subject chosen by *Dr. W. D. Stovall* of Madison.

News Items and Personals

Dr. H. F. Deicher Marks Golden Anniversary

A recent issue of the Sheboygan *Press* paid tribute to a physician who has served the community of Plymouth for 50 years. On June 4 *Dr. Henry F. Deicher* marked his 80th birthday and his golden anniversary in the medical profession, with only one regret—that he could not celebrate the occasion in the office where he practiced for 47 years. Because of ill health, Doctor Deicher was forced to curtail his active practice late in February and now treats patients at his home.

Born near Rhine Center, Doctor Deicher received his medical degree from the College of Physicians and Surgeons in Milwaukee, now part of Marquette University. During his 50 years of medical practice in Plymouth he has found time to participate in many civic and business activities.

He was president of the Plymouth Foundry and Machine Company for 25 years, served on the advisory committee of the Plymouth Branch of the Citizen State Bank for 17 years, and was president of the Plymouth Building Association for 24 years. For the past 35 years he has been health officer of Plymouth.

In April the Plymouth Kiwanis Club announced the beginning of a campaign for funds to create a medical school scholarship as a living memorial to Doctor Deicher. Funds raised in this campaign will be available to Plymouth High School students who wish to go to medical school.

Drueckers Choose Hawaii for Home, Practice

As an intern at Queens Hospital in Honolulu, Dr. Clifford Druecker, Marquette University graduate and former resident at the Milwaukee County Hospital for Mental Diseases, liked Hawaii so much that he has decided to set up permanent practice there as soon as he is released from service. Now stationed at Hickham Air Force Base in Hawaii, he expects his term of service to expire some time in the fall.

For the past two years Doctor Druecker has been in Indo China, as head of the dispensaries at Saigon and Bangkok, Thailand. Before this assignment, the doctor and his nurse-wife worked at the Leper Colony in Molokai in the Hawaiian Islands.

Bardenwerper Replaces Bultema in Waterford

The Waterford office and practice of *Dr. James H. Bultema* has been permanently taken over by *Dr. H. William Bardenwerper*, a native of Milwaukee. Doctor Bultema recently left Waterford to enter military service.

Doctor Bardenwerper is a graduate of Northwestern University and the School of Medicine of the University of Chicago. Before being recalled to army service in February 1951 Doctor Bardenwerper interned at Milwaukee Hospital and served as house physician at the Home Hospital in Lafayette, Ind. Since his release from service he practiced in Milwaukee and took two months of postgraduate study at the Cook County Graduate School of Medicine in Chicago.

Dr. W. R. Whitelaw Marks 100th Birthday

Still in good health and spirits, Dr. William R. Whitelaw of Lodi celebrated his 100th birthday April 10 at the Raebuck Nursing Home, where he has lived for several years. From two to four in the afternoon, Doctor Whitelaw was at home to his many good friends in the Lodi area who dropped in to give him their birthday congratulations and sample the huge cake provided by the Lodi Chamber of Commerce.

Born in Caledonia 100 years ago, Doctor Whitelaw received his medical degree at the University of Michigan Medical School and set up practice in Lodi in 1880. His retirement in 1940 marked the end of 60 years of continuous service to the Lodi community and surrounding area.

SHOREWOOD
HOSPITAL • SANITARIUM
2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

Dr. L. F. Nelson Opens Whitewater Office

Released last November from service in the Army Medical Corps, Dr. L. F. Nelson opened an office April 1 for the practice of medicine and surgery in Whitewater. A native of Rockford, Ill., Doctor Nelson is a graduate of the University of Illinois College of Medicine and served his internship at Providence Hospital in Seattle. Before his recent Army service, he practiced for a year in the state of Washington and spent a year in surgery at the Marshfield Clinic.

Carys Attend Conference in Mexico City

As a delegate from Wisconsin, *Dr. E. C. Cary* of Reedsville traveled with his wife to Mexico City early in April to attend the First International Congress of General Practice. En route to Mexico City, Doctor and Mrs. Cary attended a meeting of the American Academy of General Practice in St. Louis.

Grafton Has New Physician

At the conclusion of 28 months in the Navy Medical Corps, Dr. Roland M. Thurow has opened an office for the general practice of medicine in Grafton. A 1949 graduate of the Marquette University School of Medicine, Doctor Grafton formerly lived in Menominee, Mich.

Psychiatrist Opens Green Bay Office

An office for the practice of neurology and psychiatry has been opened in Green Bay by *Dr. Charles A. Wunsch* at the completion of two years in the Army as Chief of Neurology and Psychiatric Services at Chanute Field, Ill. Formerly on the full-time staff of the state reformatory, Doctor Wunsch intends to continue this association on a part-time basis. He is also a staff member at Berlin Hospital.

A native of Chicago and a graduate of the University of Illinois College of Medicine, Doctor Wunsch served his internship at St. Mary's Hospital in Detroit and has practiced in Michigan at St. Joseph's Retreat in Dearborn, the Travis City State Hospital, and St. Joseph's Hospital in Detroit. He is a member of the American Psychiatric Association and has been certified in psychiatry by the American Board of Psychiatry and Neurology.

Dr. V. J. Shippy Honored

In recognition of his over 30 years of service to the Pulaski community, *Dr. V. J. Shippy* received the Humanitarian Award of the Pulaski Chamber of Commerce at a dinner March 30. As he received a gift and a scroll, signed by more than 100 guests at the dinner, Doctor Shippy said, "My work is no special favor, but a duty."

CALIFORNIA

A new illustrated booklet is available, describing the hospitals of the California Department of Mental Hygiene and listing the professional opportunities there. Physicians are invited to write for this publication.

CALIFORNIA STATE PERSONNEL BOARD

1015 L Street Sacramento 14, California

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 Milwaukee, Wis.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting June 15, July 6, August 3
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting August 3
Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17
Fractures & Traumatic Surgery, Two Weeks, Starting June 15
Esophageal Surgery, One Week, starting June 22
Breast & Thyroid Surgery, One Week, starting June 22
Gallbladder Surgery, Ten Hours, starting June 29
Surgery of Colon & Rectum, One Week, starting September 21
Basic Principles in General Surgery, Two Weeks, starting September 21
General Surgery, One Week, starting October 5
General Surgery, Two Weeks, starting October 12
Thoracic Surgery, One Week, starting October 12

GYNECOLOGY—Intensive Course, Two Weeks, starting June 15, September 21
Vaginal Approach to Pelvic Surgery, One Week, starting September 14

OBSTETRICS—Intensive Course, Two Weeks, starting October 5

MEDICINE—Intensive General Course, Two Weeks, starting October 12
Electrocardiography & Heart Disease, Two Weeks, starting July 13
Allergy, One Month and Six Months, by appointment

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks

UROLOGY—Intensive Course, Two Weeks starting September 28

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Guest speaker at the occasion was *Dr. D. F. Gosin* of Green Bay, a friend and colleague of the Pulaski doctor, who traced the history of Pulaski since its founding in 1884 and outlined Doctor Shippy's career.

Born near Stevens Point in 1889, Doctor Shippy received his medical degree from the Marquette University School of Medicine in 1912 and interned for two years at St. Mary's Hospital in Green Bay. Before setting up practice in Pulaski, the doctor served for two years in the Army Medical Corps in World War I.

Doctor Banker Opens Manitowoc Office

Dr. R. J. Banker, a native of Akron, Ohio, and a graduate of the Northwestern University Medical School, has opened an office in Manitowoc for the practice of urology. He was recently discharged from the Navy after two years of service.

Dr. A. M. Blake Is 89

Dr. A. M. Blake of Waunakee observed his 89th birthday on April 13, but he has no intention of taking down his shingle. Few physicians in the United States can match Doctor Blake's record of 65 years of continuous practice. Born in Lodi and graduated from the Eclectic Medical College in Cincinnati, Doctor Blake set up practice in Waunakee in 1888 after a year in Lodi.

A man of many hobbies, including woodworking and gardening, Doctor Blake has a simple formula for a long life: "Exercise both mind and body, and watch the diet."

Doctor Apple Settles in Valders

Dr. Victor H. Apple of Detroit has taken over the medical practice and home of *Dr. E. W. Huth*, who after 12 years in Valders has moved with his family to Anna Maria, Florida. Doctor Huth will operate a newly constructed clinic there.

A graduate of the University of Michigan Medical School, Doctor Apple was recently discharged from service in the Army Air Force.

Dr. J. G. Beck Heads Scout Group

At the annual meeting of the Nicolet area council of the Boy Scouts of America, held on May 4, *Dr. John G. Beck* of Sturgeon Bay was elected president. Active in scout work for several years, Doctor Beck has served for the past year as district president.

Walsh Returns to Port Washington

On his discharge from active duty with the Air Force, *Dr. John F. Walsh* has reopened his office in Port Washington. A 1946 graduate of the Marquette University School of Medicine, Doctor Walsh will engage in the practice of general medicine.

Founder of Marshfield Clinic Reaches 50th Anniversary

Dr. Roy P. Potter, the last surviving founder of the Marshfield Clinic, was honored at a dinner at

the Hotel Charles in Marshfield on May 4, 50 years from the day he received his degree from the Milwaukee Medical College. For about seven years, Doctor Potter, who is 74, has been in semi-retirement, but he still visits the Clinic almost every day and is always ready to help out in an emergency.

One of the six physicians who founded the Marshfield Clinic on Dec. 23, 1916, Doctor Potter has specialized in radiology and holds memberships in the Radiological Society of North America, the American College of Radiology, and the American Board of Radiology.

Toastmaster at the dinner was *Dr. Karl H. Doege*, son of one of the founders of the Clinic. Others present included the staff of 25 professional men, 15 of whom have member status in the Marshfield Clinic.

In October of this year, Doctor Potter will be made a member of the Fifty Year Club of the State Medical Society.

Dr. Elizabeth Kane Joins Milwaukee Neuro-Psychiatric Association

A paper on "Differential Indications for the Use of Glutamic Acid," presented before the Milwaukee Neuro-Psychiatric Association on April 15, earned for *Dr. Elizabeth D. Kane* a membership in the Association. Doctor Kane is a psychiatrist in Brown County.

"The Human Heart" to Be Heard Over State Stations

The State Board of Health and the Wisconsin Heart Association have arranged with seven Wisconsin radio stations to broadcast a series of eight radio programs dealing with progress made in the treatment of heart disease.

The programs are called "The Human Heart," and star well-known actresses and actors in stories about people with heart disease. Nationally known heart specialists appear on each of the programs. Radio stations broadcasting the series as a public service feature are WATK, Antigo; WATW, Ashland; WBEV, Beaver Dam; WLIP, Kenosha; WMAM, Marinette; WSAU, Wausau; and WIBU, Poynette.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Ackerknecht Receives Medal

Dr. Erwin H. Ackerknecht, professor of history of medicine at the University of Wisconsin, has been awarded the William H. Welch Medal. He received the medal at the annual meeting of the American Association of the History of Medicine, held the second week in May in Columbus, Ohio.

The citation accompanying the medal said that Doctor Ackerknecht was picked to receive the award for his "particular contributions of outstanding merit in the field of medical history."

The Treatment of ALCOHOLISM.. A MEDICAL PROBLEM

In addition to private conferences as needed, group re-education is indispensable in leading the patient back toward total abstinence.

The concept of alcoholism as a medical problem, now generally accepted, is basic in the successful control of the "problem drinker."

At The Keeley Institute the therapeutic regimen is formulated on this premise. Specialized care of the individual patient rests in the hands of a highly experienced staff of physicians who supervise every step of the patient's progress.

Aversion treatment is not used, nor is restraint employed. Rather, the patient is aided toward rehabilitation through highly coordinated diet therapy, re-education, exercise and pleasant activities in an environment conducive to wholesome normal living—all under careful medical supervision.

The referring physician is kept informed of the patient's progress and receives a summary of the case upon the patient's dismissal.

Member, American Hospital Association
Member, Illinois Hospital Association

The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

To Serve Your Complete Prosthetic & Orthopedic Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Western Electric HEARING AID

Air and Bone Conduction

There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.

Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE

AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

Doctor Suckle Addresses Bar Association

Dr. Henry M. Suckle, Madison neurological surgeon, was the featured speaker at the April 15 meeting of the Dane County Bar Association, held in Madison at the Heidelberg Hofbrau. The doctor discussed "Medicolegal Evaluation of Head and Back Injuries."

Air Force Recalls Doctor Parks

A Madison physician for the past five years, *Dr. H. K. Parks*, reported for duty with the Air Force on April 16. He is stationed at the Air Force Hospital at Bryan, Texas. He is a veteran of World War II and holds the rank of captain.

Sheboygan Group Hears Doctor Curreri

The importance of early diagnosis and treatment of cancer was emphasized by *Dr. Anthony R. Curreri*, head of the tumor clinic at the University Hospitals, in an address at a public cancer meeting in Sheboygan. Doctor Curreri spoke under the sponsorship of the Sheboygan County Cancer Unit and the American Cancer Society. More than 400 people attended the meeting.

Two Wisconsin Physicians Take Part in Chicago Meeting

The Great Lakes Division of the United States Chapter of the International College of Surgeons held a regional meeting May 5 and 6 at the Congress Hotel, Chicago. *Dr. Arnold S. Jackson* of Madison was moderator for the Thyroid Symposium and for the Orthopedic Symposium.

Dr. Paul F. Doege, who is associated with the Marshfield Clinic, presented a paper at the meeting. His subject was "Management of the Chronically Diseased Cervix."

Columbia–Marquette–Adams

The March 10 meeting of the Columbia–Marquette–Adams County Medical Society was held at the Divine Saviour's Hospital in Portage.

When the society met at the Raulf Hotel in Portage on May 12, the guest speaker, *Dr. Arthur M. Sonneland* of Madison, discussed "Cancer of the Prostate." Doctor Sonneland is associated with the Dean Clinic.

Rock

The Rock County Medical Society and the Wisconsin Heart Association have arranged for the broadcasting of the AMA radio series, "The Heart of America," over station WCLO in Janesville. The programs are heard every Saturday morning at 9:30. There are thirteen programs in the series covering all phases of the problem of heart disease. After dramatized stories, famous heart specialists comment on the stories.

Sauk

"Illness Still Unconquered" was the title of a talk presented by *Dr. Leslie A. Osborn* of Madison at the May 12 dinner meeting of the Sauk County Medical Society. Doctor Osborn is a professor of neuropsychiatry at the University of Wisconsin and director of the Wisconsin Psychiatric Institute.

Dr. S. K. Pollack Has Certificate

At the successful completion of an intensive postgraduate course and final examination, *Dr. Saul K. Pollack* has received certification from the Chicago Institute for Psychoanalysis. Assistant professor of clinical psychiatry at the Marquette University School of Medicine, Doctor Pollack is a fellow of the American Psychiatric Association and obtained certification by the American Board of Psychiatry several years ago.

Peterman Addresses Illinois Society

Dr. M. G. Peterman presented a paper on epilepsy and convulsions at the May 20 meeting of the Illinois State Medical Society in Chicago. Doctor Peterman is a Milwaukee pediatrician.

Doctor Fox Recalled Into Service

On May 2 *Dr. Milton J. Fox*, Milwaukee, reported to Gunter Air Force Base in Montgomery, Ala., to begin service in the medical corps. He is a Navy veteran of World War II.

For the last three years Doctor Fox has been associated with the medical staff of the Veterans Administration Hospital at Wood. He also served as instructor of internal medicine at the Marquette University School of Medicine.

Schroeder Addresses Kenosha Group

"What Is Good Mental Health?" was the question answered by *Dr. Harold T. Schroeder* when he spoke before members of the Kenosha College Club at a meeting on April 21. Medical director of the Kenosha Mental Hygiene Clinic and the Racine Child Guidance Clinic, Doctor Schroeder is a graduate of the Marquette University School of Medicine, where he now serves as assistant professor of psychiatry, and has completed a three-year postgraduate course in psychiatry. He is a diplomate of the American Board of Psychiatry.

Milwaukee Academy of Medicine

The 893rd meeting of the Milwaukee Academy of Medicine, held on May 19, featured a special clinic in the afternoon and a dinner meeting at Milwaukee's University Club. The clinic was conducted at the Veterans Administration Hospital and dealt with gastrointestinal problems. At the evening meeting, Dr. John T. Reynolds of the University of Illinois College of Medicine discussed "The Causes of Persistence of Symptoms Following Cholecystectomy."

Distributors to the profession

of fine

Injectable Vitamins and Endocrines

Interstate Pharmacal Company

P. O. Box 252 Beloit, Wis.

MAIL ORDERS SHIPPED IMMEDIATELY

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin

INCREASE YOUR INCOME

Annuities issued by the Wisconsin Life Insurance Company guarantee just about twice as large a retirement income as is provided by any comparably safe investment.

The cash value of any endowment, limited pay life, or whole life policy issued by our company can be converted into a much larger monthly retirement income than the same amount of cash in other investments.

Fill out and mail to The Wisconsin Life Insurance Company, 30 West Mifflin Street, Madison, Wisconsin, the coupon below for detailed information without obligation.

Please explain how I can increase my retirement income.

Name _____

Date of Birth _____

Address _____

City _____ State _____

Wisconsin Life Insurance Co.

30 W. Mifflin St. Madison, Wis.

Milwaukee Neuro-Psychiatric Society

Rogers Memorial Sanitarium in Oconomowoc was the site of the May 20 meeting of the Milwaukee Neuro-Psychiatric Society. The after-dinner speaker was *Dr. Hans A. Reese* of Madison, who discussed "National Trends in Research in the Diseases of the Nervous System."

Milwaukee Oto-Ophthalmic Society

A thesis presentation, "Neck Abscesses," and a panel discussion on cataract surgery formed the program of the April 28 meeting of the Milwaukee Oto-Ophthalmic Society at the Milwaukee University Club. After Dr. John Russell had read his thesis to the group, the panel discussion began. With *Dr. John B. Hitz* as moderator, the panel included *Dr. Raymond C. Warner*, whose topic was "Technic of Intracapsular Cataract Extraction"; *Dr. Herbert G. Schmidt*, who discussed "Surgery of Dislocated Lenses"; and *Dr. Samuel S. Blankstein*, who spoke on "Surgery of Congenital Cataract." A question-and-answer period followed the discussion.

Milwaukee County Hospital Intern and Resident Association

May 16 was the date of the annual meeting of the Milwaukee County Hospital Intern and Resident Association. The scientific portion of the meeting, held during the day at the Milwaukee County Hospital, included talks by *Drs. Nathan Grossman, Paul G. La Bissonière, Louis Graber, James G. Garland, Louis J. Kurten, Albert Liebman, Joseph Gilbert*, and *Richard T. Flynn*. An informal dinner-dance at the Wisconsin Club in Milwaukee was held in the evening.

MARRIAGES

Dr. George W. Reis, Junction City, to Miss Florence Finger, in Sheboygan, April 11.

Dr. John W. Markson, Whitefish Bay, to Mrs. Edith Hennig, in Milwaukee, April 25.

SOCIETY RECORDS

New Members

W. J. Clothier, 717 North East Avenue, Waukesha.
R. J. Banker, 709 Washington Street, Manitowoc.
R. G. Norton, 2212 West State Street, Milwaukee.
D. F. Hammond, Chetek.
A. W. Hickey, St. Francis Hospital, La Crosse.
R. B. Rasmus, 1836 South Avenue, La Crosse.
H. M. Aitken, Sacred Heart Hospital, Eau Claire.
C. A. Wunsch, 704 South Van Buren, Green Bay.
D. F. Watzke, 130 Lathrop Street, Madison.
H. E. Thimke, Cantwell-Peterson Clinic, 117 East Green Bay Street, Shawano.
R. C. Puestow, 801 South 18th Street, Manitowoc.
J. F. Coyne, 80 Sheboygan Street, Fond du Lac.
J. H. Flinn, 16 South Henry Street, Madison.
R. P. Lyons, 110 East Main Street, Madison.
J. P. McDermott, 110 East Main Street, Madison.
O. R. McMurry, 1300 University Avenue, Madison.
A. M. Sonneland, Dean Clinic, Madison.
L. B. Stevenson, Jackson Clinic, Madison.
W. P. Deiss, 1300 University Avenue, Madison.
G. P. Gredler, 305 Court Street, Janesville.
J. M. Bond, 720 East Wisconsin Avenue, Milwaukee.
M. C. Briggs, 1409 West McKinley Avenue, Milwaukee.
I. L. Blose, Durand.
K. O. Ghormley, 1836 South Avenue, La Crosse.
W. A. Himmelsbach, 1707 Main Street, La Crosse.

Changes in Address

H. M. Bachhuber,* Athens, to Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

J. N. Moore,* Madison, to Gunter Air Force Base, Montgomery, Alabama.

T. N. Robinson, Oconto Falls, to Veterans Administration Hospital, Wood.

L. R. Pfeiffer, Turtle Lake, to Strum.

H. K. Parks,* Madison, to 3530th Medical Group, Bryan Air Force Base, Bryan, Texas.

R. F. Schaller,* San Antonio, Texas, to U. S. Army Hospital, Ft. Leonard Wood, Missouri.

J. J. Haugh,* Albany, Georgia, to A 02240789 U.S.A.F., SAM Box 49, Randolph Air Force Base, Texas.

T. A. Burns,* Milwaukee, to 0475526, New Arrival Section, Central Post Director, APO 743, c/o Postmaster, New York, New York.

I. M. Becker, Philadelphia, Pennsylvania, to 3520 North Summit Avenue, Milwaukee.

E. T. Dunn, Clifton Forge, Virginia, to Milwaukee Hospital, 2200 West Kilbourn, Milwaukee.

D. J. Malloy, Hines, Illinois, to 134 South Sixth Avenue, Maywood, Illinois.

B. L. Fabric, Milwaukee, to 7508 West Treasure Drive, Miami Beach 41, Florida.

J. H. Bultema, Waterford, to 4078 Highgate Road, Muskegon, Michigan.

A. J. Gloss, Appleton, to 121 East Main Street, Little Chute.

J. J. McLeod, Jr., Superior, 113 13th Avenue N. W., Rochester, Minnesota.

E. H. Carstens, Baraboo, to Route 1, Ogema.

D. A. Jeffries, Granite City, Illinois, to Shawano.

E. C. Jarvis, Minneapolis, Minnesota, to Tomahawk.

F. J. B. Ragaz, Madison, to 1811 Underwood Avenue, Wauwatosa.

P. S. Pierson,* Milwaukee, to Building 35, Apartment 1, U.S. Naval Hospital, Great Lakes, Illinois.

E. W. Huth, Valders, to Anna Maria, Florida.

J. F. Walsh, San Francisco, California, to 125 East Main Street, Port Washington.

M. S. LeTellier,* Ft. Sam Houston, Texas, to 01933882, Hdqts. Bt. 90th F.A. BN, APO 25, c/o Postmaster, San Francisco, California.

J. P. McCann, 503 State Bank Building, La Crosse (Incorrectly listed in May issue.)

---

* Military service.

A. J. Macht, Wood, to Marshfield Clinic, Marshfield.

L. S. Kellogg,* Oregon, to Gunter Air Force Base, Montgomery, Alabama.

S. C. Jackson,* Dodgeville, to Navy Medical Center, San Diego, California.

R. G. Gage,* Kimberly, to 14B Eagan Avenue, Langley Field, Virginia.

J. N. Dockery, Franksville, to 632 High Street, Racine.

---

* Military service.

DEATHS

Dr. Gjermund Hoyme, former Eau Claire physician, died on May 24, 1952, in Coronado, California, where he had made his home since his retirement in 1947. He was 62.

Born in Eau Claire on September 25, 1890, the doctor received his medical education at Northwestern University Medical School, graduating in 1918. He interned at Mercy Hospital, Chicago, and also at Kings County Hospital, Brooklyn, New York.

He returned to Eau Claire in 1919 and became associated with the Midelfart Clinic. He once served as chief of staff of the Luther Hospital and was a staff member at Sacred Heart Hospital, both in Eau Claire. He also served as a preceptor for the University of Wisconsin Medical School. When he moved to California, he was appointed to the Board of Directors of the Coronada Hospital.

The doctor's medical affiliations included fellowship in the American College of Physicians, certification by the American Board of Internal Medicine, and membership in the American Therapeutic Society, American Heart Association, Eau Claire–Dunn–Pepin County Medical Society, State Medical Society, and American Medical Association. He was an honorary member of the Minnesota Society of Internal Medicine and the San Diego (Calif.) Academy of Medicine.

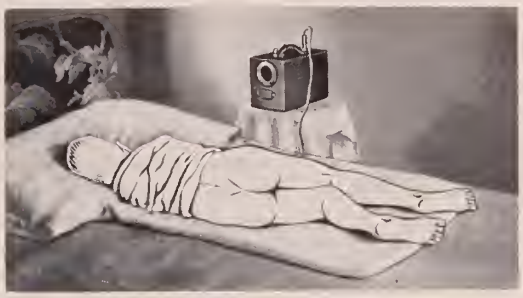
Doctor Hoyme is survived by his wife, Mrs. Grayce Hoyme, Coronado; and by his son Lt. Richard Hoyme, who is serving with the Army in Germany.

Word has been received of the death on June 1, 1952, of **Dr. Arthur E. Winter**, Tomah physician. He was 77 and had been in ill health for some years.

Born in Monroe County on November 22, 1874, Doctor Winter received his medical degree in 1898 from the Bennett College of Eclectic Medicine and Surgery in Chicago and interned at Cook County Hospital. On settling in Tomah, he became a field physician with the United States Indian Service.

Doctor Winter held membership in the Monroe County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter.



NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY

525 Holly Avenue, Madison 5, Wisconsin

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

Dr. Alfred L. Kastner, former chief of staff at the Milwaukee Children's Hospital, died at his home in Vernon on April 5. He was 74.

Born in Milwaukee on September 29, 1878, Doctor Kastner received his medical degree in 1902 from Milwaukee Medical College, a forerunner of the Marquette University School of Medicine. For over 50 years he was a practicing pediatrician in the Milwaukee area. In addition to his post at the Milwaukee Children's Hospital, he was a faculty member at Marquette for several years, served as consultant for the Milwaukee Health Department, and had been associated with the Milwaukee Hospital, the Lutheran Children's Home, and the Milwaukee Veterans Hospital.

A member of county, state, and national medical societies, Doctor Kastner was made a member of the Fifty Year Club of the State Medical Society of Wisconsin in 1952.

Survivors include the doctor's wife, Mathilda; a daughter, Mrs. Elfrieda Wilson of Mukwonago; and a son, John A., who lives in Vernon.

Dr. Clarence L. Treadwell, formerly a practicing physician at Wisconsin Dells and also at Siren, died after a short illness at an Oak Park (Ill.) hospital on April 12. He was 80.

Born in Reedsburg on September 16, 1872, Doctor Treadwell was a graduate of the University of Illinois College of Medicine. He was retired from active practice but had been doing locum tenens work for the past 10 years.

He is survived by his brother, Dr. G. F. Treadwell of Friendship.

Dr. Fred D. Curtiss, 76, a retired Kenosha physician and surgeon, died on April 22, after a short illness. He was born in Cortland, Illinois, on September 26, 1876.

A graduate of the Chicago Homeopathic Medical College, Doctor Curtiss first practiced in Fisk and in Galata, Montana. In 1918 he settled in Kenosha where he served as physician at Nash Motors for many years. He was a veteran of the Spanish–American War.

Besides his widow, Mrs. Minnie Rehm Curtiss, survivors include three sons, Charles S., Kenosha; Frank C., Billings, Montana; and Royal E., Watertown.

Dr. James F. Corbett, retired Milwaukee physician, died on April 28 at the age of 96. He was an 1880 graduate of Western Reserve University School of Medicine. Before his retirement in 1934, he had practiced medicine in California and Milwaukee.

Doctor Corbett's wife died in 1939. He is survived by three nephews and a niece.

Dr. Paul S. Epperson, Milwaukee radiologist, died suddenly at his home on Genesee Lake near Oconomowoc on April 30. He was 66.

A native of Virginia, Doctor Epperson was a graduate of the Medical College of Virginia at Richmond. He engaged in general practice for eight years on the Mesabe iron range at Biwabik, Minn., before being commissioned in the medical corps during World War I. After his return from service he became associated with the Jackson Clinic, Madison, as a radiologist. For the past 32 years he had been consulting radiologist at St. Mary's Hospital, Milwaukee, in addition to serving in the same capacity at the Memorial Hospital, Waukesha, for 13 years. He also maintained an office for private practice in Milwaukee.

A member of county, state, and national medical societies, Doctor Epperson belonged to the Radiological Society of North America, the American College of Radiology, the American Roentgen Ray Society, and was a diplomate of the American Board of Radiology.

Survivors include his wife, Grace; two sons, Dr. Keith Epperson of Milwaukee and Dr. Dean Epperson of Rochester, Minn.; and a sister, Mrs. Thomas Guthrie, Clarkton, Va.

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2811 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.

PHYSICIAN AND HOSPITAL SUPPLIES

FOUR STORES

Complete Stocks Of Medical Specialties

Orders Filled Promptly

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

A 40 Year Campaign Against Tuberculosis. By Louis I. Dublin, Ph. D., second vice-president and statistician, Metropolitan Life Insurance Company. New York, Metropolitan Life Insurance Company, 1952.

The monograph records the Metropolitan Life Insurance Company's contributions to anti-tuberculosis campaigns. The subject matter has been clearly and fascinatingly organized into a very readable manuscript. Some of the achievements of the varied programs are well documented by pertinent morbidity and mortality statistics and tables.

The first section of the book records in chronological fashion the methods which the company utilized to discover and care for its tuberculous employees. Due credit is awarded to the personnel who were responsible for each phase of these progressive and altruistic programs.

The second section is concerned with an account of the history, personnel, policies, research programs, and the results of therapy at Mount McGregor Sanatorium. This sanatorium was established by the company for the treatment of its tuberculous employees. Perhaps more emphasis justly could be given to the important therapeutic and research contributions of the medical staff of that institution.

The third section deals with numerous methods and agencies employed by the company in its anti-tuberculosis activities among its policy holders and the general public. The extent of their factual advertising campaigns, agent publicity, visiting nurses work, donations to diversified types of research, and the participation of key personnel in anti-tuberculosis organizations are described. One chapter is devoted to an account of the development and results of the "Framingham Demonstration," which clearly showed the accomplishments of a strong and well-integrated public health organization in a large urban community.

The final chapter depicts briefly the present status and future outlook in tuberculosis.—D. E. O.

Human Embryology. By W. J. Hamilton, M. D., D. Sc., F. R. S. E., professor of anatomy at the University of London at Charing Cross Hospital Medical School; J. D. Boyd, M. A., M. Sc., M. D., professor of anatomy at the University of Cambridge and Fellow of Clare College, Cambridge; and H. W. Mossman, M. S., Ph. D., associate professor of anatomy at the University of Wisconsin. Second Edition. Baltimore, The Williams & Wilkins Company, 1952. Price $9.00.

This textbook of human embryology is a readable, clear-cut, somewhat concise account of the reproductive mechanisms and the development of normal as well as abnormal fetuses. In this second edition the text has been rewritten to a large extent but brevity has been maintained. Although the total length has been enlarged by 66 pages, this increase is largely due to 69 added figures. The numerous illustrations are for the most part well executed, semi-diagrammatic drawings, many of which are in color.

Such complicated processes as formation of the germ layers, the primitive streak, intra-embryonic mesoderm, implantation, and placentation are exceptionally clearly presented. In the chapters on the development of the organs the abundant clear-cut illustrations are very informative. A few subjects are very briefly presented but in such cases references to longer accounts are cited. All in all this book, because of its comprehensive coverage, excellent illustrations, and clear-cut readable style, can be highly recommended as an authoritative account of human embryology.—T. H. B.

Antibiotic Therapy. By Henry Welch, Ph. D., Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government; and Charles N. Lewis, M. D., medical officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. Washington, D. C., The Arundel Press, Inc., 1951. Price $10.00.

Knowledge in the field of antibiotic agents continues to accumulate so swiftly that changes of practical importance for the approach to therapy

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

must be made occasionally. The relative usefulness and methods of administration of individual agents are most often involved. The physician must have access to an authoritative but concise source of information.

This single volume, "Antibiotic Therapy," supplies a brief but comprehensive summary of the important features of each antibiotic agent now available, and of certain others which show promise. The history is outlined in the first section. This is illustrated with full-page portraits of several important early contributors. Subsequent sections contain detailed information on the pharmacology, antimicrobial spectrum, and available preparations of each antibiotic. The largest section is devoted to specific infections. The experience obtained to date by clinical application of antibiotics to the therapy of each infection is outlined. The authors have been somewhat selective, to indicate established facts and provide some evaluation of the voluminous literature. This indirect evaluation is properly limited but will be helpful to the physician.

The criticisms which could be made involve aspects of the clinical application of specific agents. These are to be expected because of the rapid progress in this field and the unavoidable lapse of time. This does not detract from the work significantly, or alter the basic information included.

This book will be a worth-while addition to the physician's library.—J. W. B.

Pardon My Sneeze. By Milton Millman, M. D., Fellow, American Academy of Allergists; Member, American Academy of Allergy. San Diego, California, Frye & Smith Ltd., 1952.

This volume should answer the questions which frequently occur in the minds of allergic patients and their families. It will supplement the instructions given to the patient and in simple terms explain the rationale of an allergic regime. The section of receipts and menus should be very helpful in making an otherwise drab allergic diet more attractive to those on an egg, milk, and wheat-free diet.—H. P. D.

A Textbook of Orthopedics with a Section on Neurology in Orthopedics. By M. Beckett Howorth, M. D., clinical professor of orthopedic surgery, New York University Postgraduate Medical School. In association with Fritz J. Cramer, M. D., Donovan J. McCune, M. D., A. Wilbur Duryee, M. D., J. William Littler, M. D., and Walter A. Thompson, M. D. Philadelphia and London, W. B. Saunders Company, 1952. Price $16.00.

A not overly-large book, this volume is a successful attempt at a concise, scholarly presentation of the basic facts of etiology, pathology, diagnosis, and treatment of diseases and abnormalities of the neuromusculoskeletal system.

It is broadly divided into a section on principles of orthopedics—history, anatomy, examination, diagnosis, and treatment; a section on the regional aspects of orthopedics—first in the body as a whole and then with respect to its various parts; and finally a section on specific disorders. The book is clearly and pointedly illustrated throughout with inclusion of a series of drawings and photographs on the dynamics of normal and abnormal gaits and good and poor postures.

The principles of rest, exercise, balanced traction, shoe fitting, and application of orthopedic appliances are happily included, as well as the development of posture and gait in the infant.

The bibliography is limited to the more important contributions and is adequate.

This book is highly recommended.—H. I. O.

Advances in Medicine and Surgery: from the Graduate School of Medicine of the University of Pennsylvania. Illustrated. Philadelphia and London, W. B. Saunders Company, 1952. Price $8.00.

As noted in the preface, this volume represents the publication of a series of symposia dealing with 10 topics of considerable interest to practicing physicians. While in the main they represent a part of a course in postgraduate medicine given at the University of Pennsylvania, they are also a carefully planned group of papers dealing with current problems of interest to all. There are over 60 contributors and each one has written on fields of his own special interest. There are tables and illustrations where indicated, and there is a good up-to-date list of references following each of the various papers.

To list all of the individual papers would take considerable space; however, the 10 symposia are (1) The Present Status of Adrenal Cortical Hormones, (2) The Role of Potassium in Health and Disease, (3) Hypertension: Newer Aspects of Medical and Surgical Treatment, (4) Newer Concepts in Preoperative Evaluation and Preparation of Patients, (5) Thromboembolism, (6) Pulmonary Infections, (7) The Relief of Pain, (8) Current Status of the Cancer Problem, (9) Recent Developments in Viral Disease, and (10) Functional Disorders.

The various symposia are well discussed, and this volume well represents a complete postgraduate course in itself. Although the course seems designed for general practitioners, there is a wealth of material excellently presented for anyone in the practice of medicine.—K. E. L.

Bone Tumors. By Louis Lichtenstein, M. D., senior pathologist, General Medical and Surgical Hospital, Veterans Administration Center, Los Angeles; formerly associate pathologist, Hospital for Joint Diseases, New York; consultant in bone tumors, Tumor Registry of the California Medical Association Cancer Commission; sometime lecturer in bone pathology, Medical Extension, University of California at Los Angeles. St. Louis, The C. V. Mosby Company, 1952. Price $10.50.

The advent of this monograph hard on the heels of several comprehensive treatises on the same subject may seem superfluous or at most an ornamental edition. Yet in the hands of the reviewer casual perusal was fittingly and rapidly converted to avid and critical study by dint of the author's experience and skill in the field. The lucidity of his style is a pleasing literary feature and also amplifies the adage that what is good is twice good by being brief. In the handling of clinical, radiologic, and pathologic problems, he avoids no issues germane to the subject and assembles his facts with precision and conviction. Phantom or academic problems are recognized and dismissed and bias is given to practical issues. Authorities do not stand in the way when confirming experience is missing.

It is not within the reviewer's purview to decide whether the author underscores the deficiencies of radiologic diagnoses too heavily, but his restrictions certainly merit solemn attention. On the other hand, it is well to see the chondrosarcomas and osteosarcomas definitively separated, the malignancy of some giant cell tumors substantiated, and identity of chondromyxoid fibroma advocated. There is less enthusiasm for his chondroblastoma, however. We would conclude that this is a unique contribution and represents a genuine advance.—J. W. H.

Principles of Refraction. By Sylvester J. Beach, A. B., M. D., F. A. C. S., consultant, Staff Maine Eye and Ear Infirmary; chief ophthalmologist, Portland City Hospital; and member of staff, Maine General Hospital. St. Louis, The C. V. Mosby Company, 1952. Price $4.00.

This volume is characterized by its simplicity, directness of approach, and brevity. The author presents the subject matter, optics, by easy-to-perform experiments and obviously shuns the mathematical approach. Types of refractive errors are briefly described and diagrams used freely to illustrate their significance. The technic of refraction by the dry and cycloplegic methods is next considered and the advantages and disadvantages of each method are outlined. The chapter on "Treatment of Ametropia" is disappointingly short, the author holding his material to the most basic principles. There is a dearth of help in this chapter for the myriad problems which arise during the course of day-to-day treatment of refractive errors. The final chapter deals with ocular neuroses. Here the author is at his best and gives us sound advice in a field of therapeutics which is so poorly understood and practiced. Doctor Beach's book is a worth-while addition to our refraction literature.—P. A. D.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

WANTED: General practitioner as associate in central Wisconsin. Excellent hospital facilities. Unlimited opportunity. Salary at first, partnership later. Address replies to Box 486 in care of the Journal.

FOR SALE: 100 ma Mattern x-ray with tilting table, fluoroscopy, spot device, movable table, and remote control. It is 10 years old and in excellent condition. Price $1,400. Owners selling because they are now in a group practice. Address replies to Drs. Koepp and Moss, 1554 Main St., Marinette, Wis.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor s needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE: One 20 ma Fischer x-ray mobile unit, bucky table, and other complete accessories. Excellent condition. Very reasonable. Address replies to Box 487 in care of the Journal.

ASSOCIATION AVAILABLE: Small group in city of 6,000, with excellent hospital facilities desires associate with experience in major surgery. Liberal salary and partnership association. Address replies to box 471 in care of the Journal.

WANTED, otolaryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

PHYSICIAN-SURGEON WANTED for an industrial community serving 3,000 people within a 20-mile area. We will lease the attractive doctor's residence and a fully equipped first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year of his practice and should increase each year thereafter. Available on or after June 1. Call or write: Goodman Lumber Company, Goodman, Wisconsin.

WANTED: Used hospital size Bovle Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5–9100.

PHYSICIAN WANTED as associate in busy, successful practice including surgery in rural, resort, and railroad town of 3,000 in northwest Wisconsin Indianhead region. Fully equipped 13-room modern brick clinic to be completed Sept. 1. Excellent hospital facilities near-by. Local hospital building campaign under way. Salary, percentage, or guaranteed minimum basis initially, with eventual partnership. Address replies to Box 496 in care of the Journal.

WANTED: Physician as an associate in general practice, preferably with surgical training and service exempt. City of 10,000 population in north central Wisconsin, with excellent hospital facilities and on a salary basis with eventual partnership. Address replies to box 473 in care of the Journal.

WANTED: Pediatrician, or general practitioner willing to do large share of pediatrics, in an active group practice in suburban Milwaukee. Address replies to box 475 in care of the Journal.

FOR SALE: Hellige colorimeter for blood sugars, with glassware but no chemicals, $15. Also cystoscopy 3-cell battery box, $10. Address replies to R. M. Rogers, M. D., Tigerton, Wis.

WANTED: Locum tenens for the month of July or August. Address replies to H. Y. Fredrick, M. D., Westfield, Wis.

PHYSICIANS AND PEDIATRICIANS, with or without public health training, needed in Maternal and Child Health program at salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Address replies to E. R. Krumbiegel, M. D., City Hall, Milwaukee, Wis.

CLINIC in Milwaukee needs general practitioner, internist, and pediatrician. Address replies to Box 488 in care of the Journal.

PHYSICIAN WANTED by group of four doctors whose practice is located in city of 12,000 in southeast Wisconsin. Excellent hospital facilities. Liberal salary leading to early partnership. Address replies to Box 498 in care of the Journal.

WANTED: Urological table with built-in bucky. Must be relatively new and in good condition. Address replies to Milton Margoles, M. D., 1971 W. Capitol Dr., Milwaukee, Wis.

RADIOLOGIST with ten years' experience, Board certified, desires opportunity for group practice or contact with men interested in forming group. Address replies to Box 489 in care of the Journal.

WANTED: G.P. to work with 2 other G.P.'s in a modern and complete office in south-central Wisconsin. Modern hospital within 15 miles. Ideal hours and working conditions. Address replies to Box 499 in care of the Journal.

EXCELLENT opportunity for general practitioner in a small group located in northeastern Wisconsin. Percentage basis with liberal salary guarantee until established. Permanent position. Address replies to Box 500 in care of the Journal.

ASSOCIATION WANTED: Physician who is tired of solo practice desires association with physician or group to do general practice. Address replies to box 483 in care of the Journal.

PRACTICE FOR SALE: Completely modern clinic and home doing net of $30,000 a year. For full information write to Box 501 in care of the Journal.

FOR SALE: Home and office combination in city of 1,000 in southern Wisconsin. Requires considerable investment but seller is willing to accept payment over a period of 10 to 15 years. Address replies to Box 490 in care of the Journal.

PHYSICIAN WANTED, preferably with education or experience in addition to the one-year internship, for a general practice which includes considerable surgery. Practice located in a central Wisconsin city of 5,000 with large drawing area and excellent hospital facilities. Arrangements for association open. Address replies to Box 491 in care of the Journal.

FOR SALE: One used GE, F–2, shock proof, wall model x-ray unit especially designed for taking sinus and mastoid x-rays. Every conceivable angle and stereos possible. Complete with modern hand timer, four 8 x 10 cassettes, and accessories, including a 3 gallon composition Buck tank. Address replies to W. G. Meier, M. D., Sheboygan, Wis.

FOR SALE: Entire practice and equipment of busy G.P. May lease same office space. A find for anyone starting in Milwaukee. Owner is leaving for residency. Address replies to Box 502 in care of the Journal.

EENT ASSISTANT wanted by certified otolaryngologist. Board eligible man in either specialty preferred; but will train young man and pay liberal salary. Permanent position. Good future. Address replies to Box 493 in care of the Journal.

FOR SALE: Schindler–Cameron flexible gastroscope, completely equipped and in perfect condition. Also a Boros–Cameron flexible esophagoscope (never used) with hooked handle. Completely equipped. Address replies to Box 503 in care of the Journal.

UNUSUAL OPPORTUNITY to do general practice in Madison, Wis., as associate and later partner. Well established practice. Salary open. Address replies to Box 494 in care of the Journal.

WANTED: Young, progressive clinic in Wisconsin needs obstetrician and gynecologist, certified or Board qualified, and general practitioner. Excellent opportunities. Address replies to Box 495 in care of the Journal.

FOR SALE OR LEASE: Doctors' medical building in Marinette, Wis., suitable for combination clinic and living quarters. Excellent location. Community of 30,000. Hospital facilities. Active medical practice has been carried on at this location for over 50 years. Write to H. L. Jorgenson, M. D., 8163 N. E. Second Avenue, Miami, Florida.

PHYSICIAN WANTED, preferably one with one or two years experience in private practice, as an associate in a well established general and surgical practice in a city of over 30,000. Address replies to box 478 in care of the Journal.

ROEMERS—MILWAUKEE

Surgical Supplies

Hospital Supplies

Office Furniture

Laboratory Supplies

* * *

Complete Service to the Medical Profession

* * *

Roemer Drug Company
606 No. Broadway
Milwaukee 2, Wisconsin

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

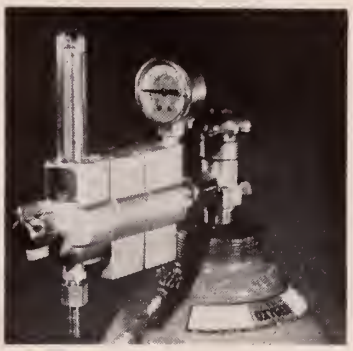
PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

specialized service assures *"know-how"*

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 8-1021

A CLINICAL REGULATOR

Can Reduce Oxygen Costs



A truly clinical oxygen therapy regulator, the "LINDE" R-501, is designed for the exacting and unfailing service expected by hospitals and physicians. It's built to go a long time between repairs, therefore costs less to operate.

Attach the apparatus, select the liter flow, and it stays constant regardless of administering equipment used, as long as oxygen supply lasts. And, with the R-501 you can be assured your patient is getting exactly the oxygen flow indicated.

Let us show you why so many physicians and hospitals are now depending on the "Linde" R-501 for superior oxygen therapy service.

available from any of these distributors of

Linde
OXYGEN U.S.P.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding and Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS
LITER FLOW ADAPTORS • OXYGEN THERAPY ADMINISTERING EQUIPMENT

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors -- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate -- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

Page

Abbott Laboratories ---------- 10, 11, 20
Audiphone Utilities ---------- 34
Ayerst, McKenna & Harrison, Ltd. ---------- 13

Baker Laboratories ---------- 14
Barr X-Ray Company ---------- 35
Benson Optical Company ---------- 16
Bergmann Prescription Center ---------- 29

California State Personnel Board ---------- 32
Central Drug ---------- 29
Coca Cola Company ---------- 41
Cook County Graduate School of Medicine ------ 32

Doerflinger Artificial Limb Co. ---------- 40

Endocrine Laboratories ---------- 37

General Electric Company, X-Ray Department -- 17

Hotel Schroeder ---------- 5
House of Bidwell ---------- 34
Hurley X-Ray Company ---------- 34

Interstate Pharmacal Company ---------- 35

Keeley Institute ---------- 33
Kennedy-Mansfield ---------- 29

Lakeside Laboratories ---------- 9
Lederle Laboratories ---------- facing page 30
Lilly, Eli and Company ---------- 22
Linde Air Products ---------- 43

Mallard, Incorporated ---------- 8
Mallatt Pharmacy ---------- 29
Mather Pharmacy ---------- 29
Mayer Drug ---------- 29
Mead Johnson and Company ---------- 47
Medical Protective Company ---------- 43
Merck and Company ---------- facing page 18
Milwaukee Sanitarium ---------- 48

New York Polyclinic ---------- 4

Orthopedic Appliance Company ---------- 32

Parke, Davis and Company ---------- 2, 3
Pfizer, Charles and Company, Inc. ---------- 19
Physicians & Hospitals Supply Co., Inc. ---------- 12
Physicians Casualty Association ---------- 25
Pogue, Mary, School ---------- 4
Professional Business Service ---------- 345

Rennebohm's ---------- 29
Roemer Drug Company ---------- 43
Rogers Memorial Sanitarium ---------- 48

S. and L. Signal Company ---------- 37
Sacred Heart Sanitarium ---------- 25
St. Croixdale Sanitarium ---------- 5
Schering ---------- 7
Schieffelin and Company ---------- 5
Searle, G. D. and Company ---------- 23
Shorewood Hospital Sanitarium ---------- 31
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp. ---------- 6
Stanley, Inc. ---------- 38
Summit Hospital ---------- 16

Time Insurance Company ---------- 343

Upjohn Company ---------- 15

Winthrop-Stearns, Inc. ---------- 18
Wisconsin Life Insurance Company ---------- 35
Wyeth ---------- 21

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 JULY 1953 Number 7

General Uses of ACTH (Corticotropin) and Cortisone

By JOSEPH H. SAGI, M.D., FRANK BELFUS, M.D., and FRED P. KRUMENACHER, M.D.
Milwaukee

THE subject of the therapeutic value of ACTH (corticotropin) and cortisone has become so controversial that we have seen fit to crystallize our experience for the past two and a half years.* We are presenting an evaluation of the first 241 patients treated with these hormones in two private general hospitals in Milwaukee. (Table 1)

Method of Study

The administration of ACTH and cortisone was under the supervision of individual staff physicians. No selection of diseases was made and no cases have been eliminated because of good or bad therapeutic results. It was noted that in the earlier use of these drugs the Thorn test[1] and frequent eosinophil counts were done. As more personal experience was gained there was a trend primarily toward regulating the dosage according to the clinical response of the patients. A low sodium diet and potassium chloride were frequently given during therapy. Likewise antibiotics were coadministered whenever indicated.

The modes of administration consisted of the conventional intramuscular method for both drugs; the oral, intramuscular, and topical methods for cortisone; and the intravenous administration of ACTH in 1,000 cc. of 5 per cent glucose in water.[2]

Clinical Data

The therapeutic results in the first 241 cases treated with the hormones are recorded and cover the period of hospitalization only. (Table 1) A number of the patients were discharged from the hospital under continued therapy while others required no maintenance treatment.

Arthritis—The immediate results obtained in the treatment of rheumatoid arthritis with ACTH and cortisone were as spectacular as those reported by other investigators.[3] Usually in two or three days pain decreased sufficiently to permit more effective use of physical therapy than ever before thought possible. Sedimentation rates decreased and the classical signs of inflammation progressively subsided. The range of motion in the involved joints increased; old deformities, however, were not changed. A definite sense of well-being was induced in a degree depending on the severity of the original disease. Usually the more severe the case, the more marked the sense of well-being. Of 66 cases of rheumatoid arthritis, 25 had excellent results, 37 good results, and only 4 had poor results. These responses generally were obtained more rapidly with ACTH than with cortisone. Although results were generally poor in osteoarthritis, a good response was occasionally observed in a patient. This has been confirmed by Boots.[4]

Acute Rheumatic Fever—Good results were obtained with these drugs in the treatment of 3 out of 5 patients with acute rheumatic fever. There was a prompt response with a decrease in the sedimentation rate, fever, and heart size. The other 2 patients responded poorly.

Blood Disorders—The results of therapy in chronic leukemias were poor. In a case of acquired hemolytic anemia, a favorable response was obtained.

CASE 1—E. T., a 70 year old white female, entered the hospital for diagnosis and treatment of an unexplained anemia. She had been well until one month before admission, when she had fever, flatulence, and epigas-

* The authors wish to acknowledge the cooperation of the attending physicians and pathologists at Columbia and Milwaukee Hospitals for case material as well as for guidance in preparing this article.
This study was supported in part by a grant from the fund for Scientific Advancement and Education of Columbia Hospital.
The senior author also wishes to acknowledge the assistance given by the Armour Laboratories (especially Dr. Joseph Hubata) in technical details and in furnishing Acthar for some of these cases.

tric pain. The latter two symptoms were absent on admission. When hospitalized, she received 3 transfusions. With the last of these, she had chills and fever.

Laboratory findings: On admission the hemoglobin was 7.8 Gm., the red blood cell count 2,740,000, and the platelet count 79,000. Bone marrow aspiration was done. The serum bilirubin was 3 mg. per hundred cubic centimeters, the erythrocyte fragility was increased, and the Coomb's test was positive. A diagnosis of an acquired hemolytic anemia of undetermined origin was made.

During her hospital stay the spleen became palpable. In view of this and the failure of the anemia to respond to conventional forms of therapy a splenectomy was performed. The blood count remained high for several weeks postoperatively, even though the serum bilirubin and erythrocyte fragility were unchanged. When the blood count began to fall, the patient was given ACTH. This drug had been administered preoperatively for two weeks without effect. However, when it was given postoperatively, 25 mg. intramuscularly every 6 hours, a slow but steady improvement in the red blood cell count was noted. At the end of three weeks, the hemoglobin had increased from 7.8 Gm. to 12.4 Gm., where it remained steady. The dose of ACTH was slowly tapered until the patient received only 5 mg. a day intramuscularly. In conjunction with a splenectomy, ACTH aided in maturation of the erythrocytes.

Acute Eye Diseases—In the field of ophthalmology ACTH and cortisone proved to be of great value. In only a few instances, local cortisone was employed. Chorioretinitis, iritis, recurring keratitis, and iridocyclitis responded favorably to treatment. Only retrobulbar neuritis failed to respond. Methods of administration have been well outlined by Gordon.[5]

Dermatitis—Good results were generally obtained in dermatitis venenata and dermatitis medicamentosa, and excellent results in angioneurotic edema and urticaria caused by penicillin. The pruritus usually disappeared promptly after the first few injections of ACTH, while the rash responded more slowly. The least satisfactory responses were noted in atopic eczema, in which the results ranged from poor to only fair.

Case 2—E. T., a 38 year old female, was admitted to the hospital with massive generalized penicillin urticaria of three days' duration. Since the antihistaminics gave no results, the patient was placed on ACTH, 15 mg. intramuscularly every 6 hours. Following the fifth dose the urticaria was completely cleared, and the patient was discharged from the hospital.

Excellent results were observed with the topical application of cortisone in 2 out of 3 cases of sensitization dermatitis. The following case history represents an illustration of our results.

Case 3—F. H., a 49 year old white male, entered the hospital with a dermatitis involving the left foot and ankle for the past 13 years and the hands and arms for the past 8 months. Five years before, a histopathologic examination had revealed pityriasis rubra pilaris.

On physical examination, the left ankle, foot, and toes were red, crusted, papular, and eczematoid, and there was also mild scaling and maceration of the toes. The fingers, hands, and forearms were covered with papular, erythematous rash. A diagnosis of infectious eczematoid dermatitis of the feet and sensitization dermatitis of the hands was made.

Cortisone ointment, 0.3 per cent, was applied to the left foot every 3 hours. In one week of therapy in the hospital the crusting, oozing, and pruritus had disappeared and complete recovery occurred after eight weeks of therapy at home. No effect on the circulating eosinophil count was noted.

Miscellaneous—In calcareous tendonitis, the pain decreased sufficiently with ACTH therapy to permit an early increased range of motion in conjunction with physical therapy.

A case of *regional ileitis* responded well.

Case 4—L. I., a 51 year old white female, entered the hospital complaining of abdominal pain and diarrhea. Four years previously a resection of 40 inches of ileum, the ascending colon, and a portion of the transverse colon had been done because of regional enteritis. She had been having almost continuous difficulty ever since, including several attacks of bowel obstruction. Examination on admission revealed a tender abdominal mass about the size of a grapefruit. An immediate response, characterized by subsidence of abdominal pain and return to practically normal bowel movements, followed the intravenous administration of 50

mg. of ACTH over a 12 hour period. Improvement continued during the two months of hospitalization. The dose of ACTH was gradually tapered, so that at the time of discharge the patient was receiving 2½ to 5 mg. of the drug a day, a dose which maintained the therapeutic response. Towards the end of her hospitalization, a long-acting preparation of ACTH was effectively employed for maintenance purposes. Cortisone was observed to be unsatisfactory. No toxic manifestations were noted except for a slight rounding of the face.

Ulcerative colitis responded well to the administration of ACTH in two instances, and not at all in one; two other patients, treated with cortisone, died. Autopsy examination of one patient revealed innumerable perforations of the entire large bowel.

CASE 5—D. E., a 22 year old nurse, entered the hospital complaining of cramping pain in the lower part of the abdomen and of frequent loose stools which contained mucus and blood. This patient was a known case of ulcerative colitis for the past two years and had had one previous exacerbation of 10 weeks' duration with the usual medical treatment. The present exacerbation of symptoms followed an upper respiratory tract infection two weeks before.

Therapy included continuous infusions of 20 mg. of ACTH in 1,000 cc. of 5 per cent glucose in distilled water daily. On the third day of treatment the temperature dropped to normal. On the fifth day, diarrhea and bloody stools began to diminish rapidly. An increased feeling of well-being was noted and the patient's appetite increased. During ACTH therapy some water retention was observed, but when the therapy was discontinued, the patient urinated very effectively. The patient was discharged in remission after six days of treatment with ACTH. The dose of ACTH was tapered to 5 mg. in 24 hours before it was discontinued.

CASE 6—T. R., a 57 year old woman, entered the hospital complaining of 15 watery stools a day for the past three weeks. No mucus or blood were present in the stool. Examination revealed no abdominal rigidity; tender, spastic areas of the colon were, however, present. Roentgenograms confirmed the diagnosis of ulcerative colitis.

The patient was placed on the usual medicinal regimen, including antibiotics. Soon a nodular vesicular dermatitis on fingers, hands, arms, ears, and the posterior part of the neck developed, which progressed in spite of the cessation of antibiotic treatment and the institution of an antihistaminic preparaion. This was believed to be a case of pyoderma gangraenosum. As the symptoms continued to increase in severity ACTH was begun, 15 mg. intramuscularly every 6 hours. The initial response was excellent, with a decrease in fever and in the number of bowel movements, and the rash disappeared entirely. Despite continued hormonal treatment, however, improvement persisted only about one week. The patient had a relapse and the abdomen became distended and tender. ACTH was then stopped and 100 mg. of cortisone was administered every 12 hours. The symptoms continued to progress, however. The patient became very lethargic and and an electrolyte imbalance developed.

Despite all forms of supportive treatment, the patient died four weeks after admission. On postmortem examination numerous perforations of the entire large bowel, varying in size from 1 mm. to 1 cm. in diameter, were noted. There were also many small abscesses between loops of small intestine, and patches of fibrous exudate covered most of the lower abdominal organs.

A case of chronic *pulmonary berylliosis* responded well to ACTH and cortisone, but a patient with pulmonary fibrosis of undetermined cause remained unchanged.

Two cases of *severe shock* following extensive trauma improved after the administration of ACTH.

CASE 7—M. C., a 46 year old white female, was admitted to the hospital with a compound fracture of the left femur, and avulsion of the quadriceps femoris and hamstring muscles. She had attempted suicide by throwing herself in front of a streetcar.

After an unsuccessful course of conservative therapy, the left leg was amputated, at which time a great deal of necrotic tissue and large abscesses were encountered. Postoperatively, there was generalized toxemia and temperature of 103 F.; she was stuporous and appeared terminal. Because of the action of ACTH in increasing tissue resistance to toxins, for three days the patient was given 25 mg. of ACTH intravenously over a 10 hour period each day. There was rapid improvement in her condition and she went on to an uncomplicated recovery.

Nephrosis responded well.

CASE 8—J. H., a 23 year old acutely ill white female, was admitted to the hospital with dyspnea, pulmonary edema, anasarca including ascites, and a blood pressure of 140/120. Six months previously she had had an infection of the respiratory tract and generalized moderate edema which disappeared within one week. One month before hospitalization, general edema and oliguria were noted.

The total protein was 4.2 Gm. per hundred cubic centimeters of blood, with albumin 1.6 Gm. and globulin 2.6 Gm. The patient received thoracentesis and transfusions of whole blood. On the thirteenth day of hospitalization 20 mg. of ACTH was administered intravenously over an 8 hour period. This was continued daily for 12 days. On the sixth day of therapy the patient urinated and on the twelfth day edema increased.

ACTH therapy was resumed six days later and the dosage was gradually increased to 40 mg. intravenously. On the tenth day of this second series of treatment the patient urinated and ACTH administration was discontinued. Clinical improvement continued although the blood protein did not increase.

Discussion

In compiling the results observed in 241 cases, the diseases have been reported in the order in which we have had the most experience. In the light of these results, what can one expect from these drugs? The data in Table 2 attempt to supply an answer to this question.

The ideal indication for the use of these drugs is in disease requiring short-term therapy. It is becoming more apparent that there are a number of important diseases commonly encountered which respond to short-term treatment with ACTH and cortisone more effectively and rapidly than with the usual therapies. Included in this category are acute inflammatory eye diseases, dermatitis medicamentosa such as that caused by penicillin, urticaria, and serum sickness.

These drugs may be life saving in certain emergencies such as shock and extensive burns. In these instances ACTH is the preparation of choice because of the rapidity of its action.

In status asthmaticus where the patient is resistant to other forms of therapy or where rapid relief is needed these drugs may be of the greatest importance.

Gout responded somewhat more quickly when ACTH supplemented colchicine than when the latter was administered alone.

Rheumatic fever is a disease where we should expect the most beneficial results. It is included in the class of acute self-limited diseases which respond to short-term ACTH and cortisone therapy. Until the advent of these drugs, little else had reduced the high incidence of cardiac complications.[6] Although the enthusiasm of Wilson[7] for the use of ACTH has not been shared by others,[8] even these latter authors give some justification for the use of the hormones.

In acute self-limited diseases these hormones can abort the process. In chronic diseases, however, beneficial results are maintained only so long as therapy is continued. A decision must be made as to the indication for maintenance therapy. This is the greatest handicap in the use of these medications for rheumatoid arthritis. Once the patient has experienced even the subjective improvement afforded by the drug, he is loath to give it up. Thus, a balance sheet must be prepared in each case to evaluate the indications for initiation of therapy and the hazards of complications and relapse. If any other drug is effective it should be used. If all else fails and the patient is the breadwinner of his family, bedridden with rheumatoid arthritis, the decision is easy. Rehabilitation for any period of time is of value.

The response in ulcerative colitis was quite dramatic and heartening, both in our experience and in that of others. The hazards of perforation and infection must be considered, but the latter can be well controlled with adequate doses of antibiotics. Overwhelming septicemia or peritonitis, such as that which occurred in one of our cases, may lead to the sudden death of the patient. This is probably due to a depression of the defense mechanisms after a decrease in fibroblastic proliferation and phagocytic activity[9] induced by the use of the hormones. Probably this also is the cause of the development of active tuberculosis which has been reported.[10]

The importance of the proper use of antibiotics in these cases cannot be too strongly stressed. Kinsell[11] believes that their use is mandatory in overwhelming infections. In the fatal diseases listed (Table 2), when all else has failed, the use of ACTH or cortisone in prolonging life is justified. Although our

experience with disseminated lupus erythematosus has not been good, the data reported in the literature are encouraging.[12] Even in the leukemias, when the ultimate results are poor, remission may be obtained, especially in the acute forms of the disease.

Dosage

The hormones should be given in large doses at the beginning of treatment. This would be 25 to 50 units* of ACTH given intramuscularly every 6 hours or 50 to 75 mg. of cortisone given orally every 4 hours. For severe cases of usually fatal diseases, this dosage should be doubled or tripled before failure of treatment is admitted. Once results are obtained, the dose should be decreased to the minimal effective level if maintenance therapy is contemplated. This varies widely, and must be individualized for the different diseases and patients.

It is well to emphasize the importance of the intravenous use of ACTH. It was observed that intravenous doses of 6.25 mg. of ACTH resulted in a greater clinical response than 200 mg. of either ACTH or cortisone administered intramuscularly. Therefore it is not true to state that treatment with ACTH or cortisone has failed until the intravenous method of administering ACTH has been employed. On several occasions, when large doses of cortisone given orally or intramuscularly or of ACTH given intramuscularly have failed to effect a response, the use of ACTH as a continuous intravenous infusion produce a prompt and favorable result.

The recent purified preparations of ACTH in gelatin have proved in most clinical situations to be the product of choice. The authors have used such a product for several months.** It may be given subcutaneously or intramuscularly and is well tolerated at the injection site. Its effect is rapid and yet prolonged. This prolonged clinical action redues the frequency of injections and the amount needed. Forty mg. has about the same effect as 100 mg. given in other forms. No instances of acquired resistance or sensitivity reactions to this preparation have been noted. In its fluid state it can be conveniently administered through a small-gauge needle, #22–#25.

* One unit is equal to 1 mg. of ACTH. The latter measure has been discarded.

** HP ACTHAR GEL supplied through the courtesy of the Armour Laboratories.

In diseases limited to the skin or mucous membranes, topical application of cortisone is sometimes effective, as observed in the 3 cases treated. It has also been found to be of value in treating acute inflammatory eye disease, sensitization dermatitis, psoriasis, and an occasional nasal allergy.

Effects of Overdosage

The overstimulation effects inherent in long-term maintenance therapy with these drugs must be carefully evaluated and understood by both the physician and the patient before they are begun.

Edema may result from prolonged treatment with these drugs, but more commonly it is due to overdosage. This is caused by retention of sodium with coresponding retention of water. Diuretics may be of value, but in some cases the hormones have to be discontinued to effect adequate diuresis. Hypertension has been reported but we have not encountered this complication.

Hirsutism, rounding of the face, and striae may all appear to a degree simulating Cushing's disease in patients receiving prolonged therapy.

Acute psychoses may develop, but fortunately these conditions are reversible and usually will subside when treatment is discontinued or the dosage lowered. One patient in our series,[13] treated with cortisone, committed suicide before the extent of her mental disturbance was realized. Another patient required heavy sedation.

Although much has been said about glycosuria and diabetes mellitus being precipitated by these drugs, these were not noted in our series.

The masking effects of the drugs on pain or the symptoms of infection must be kept in mind. The development of an allergic reaction to ACTH has been reported and should be considered, especially when this hormone is administered intravenously. However, we have not encountered this complication.

The reactivation of chronic peptic ulcers or the sudden occurrence of acute ulcers with concomitant hemorrhage or perforation is another hazard which must be kept in mind.

Finally, adrenal cortical suppression or atrophy occurs when cortisone is used. Normal activity may not return for as long as 60 days.[14] If treatment is abruptly stopped, the patient will react as he does in Addison's

disease to any sudden stress. This is especially true in the case of surgery, when 200 to 300 mg. of cortisone should be given intramuscularly for two days preoperatively, on the day of surgery, and for two days postoperatively or as long as the patient is unable to take cortisone orally. While ACTH is being used there is no danger, since the adrenal cortex is being continuously stimulated, and the use of the drug can be continued during periods of stress. The dosage of both drugs should be tapered gradually when the decision has been made to discontinue their use.

Summary

After two and a half years of therapeutic experience with these drugs, certain conclusions may be made. They are often the most effective drugs available to control rheumatoid arthritis and permit the patient to continue an active life. They may aid in the rehabilitation of arthritics who have been long disabled. The acute inflammatory stages of rheumatic fever sometimes are dramatically controlled. They may be life saving in certain shock-like states. They may quickly abort certain types of dermatitis medicamentosa, especially penicillin urticaria. They may prolong life in fatal diseases such as disseminated lupus erythematosus or the leukemias. Bleeding manifestations of some of the blood dyscrasias may be controlled without other changes in the original disease process.

Dosage varies for the individual disease and patient, but maintenance should always be kept at a minimum. Therapy should be stopped by tapering the dosage.

Conclusions

1. The primary value of ACTH and cortisone lies in the treatment of acute self-limited diseases which, because of their severity and failure to respond to other drugs, require alleviation.

2. The drugs are never curative but often satisfactorily modify a disease process.

3. The possibility of dangerous results caused by the physiologic action of these potent hormones must always be weighed against the therapeutic effects which are anticipated.

4. Bearing the above in mind ACTH and cortisone are useful drugs.

(J.H.S.) 425 East Wisconsin Avenue.

REFERENCES

1. Thorn, G. W., and others: Test for adrenal cortical insufficiency; response to pituitary adrenocorticotropin hormone, J.A.M.A. 137: 1005–1009 (July 17) 1948; correction 137:1544 (Aug. 21) 1948.
2. Gordon, E. S., Kelsey, C., and Meyer, E. S.: Adrenal stimulation by intravenous ACTH, Proceedings of the Second Clinical ACTH Conference, Garden City, N. Y., The Blakiston Company, 1951, vol. 2, pp. 30–37.
3. a. Coss, J. A., and Ragan, C. A.: Combined use of cortisone, ACTH, and rehabilitation techniques in certain arthritis problems, Arch. Phys. Med. 32:572–574 (Sept.) 1951.
   b. Steinbrocker, O., and others: ACTH and cortisone as therapeutic agents in arthritis and some locomotor disorders, Bull. New York Acad. Med. 27:560–576 (Sept.) 1951.
4. Boots, R. H., and others: Degenerative joint disease of the hip; relief of symptoms following cortisone therapy, J.A.M.A. 147:549–551 (Oct. 6) 1951.
5. Gordon, D. M., McLean, J. M., and Koteen, H.: The use of ACTH in ophthalmology, Proceedings of the Second Clinical ACTH Conference, Garden City, N. Y., The Blakiston Company, 1951, vol. 2, pp. 457–472.
6. Levine, S. A.: Clinical Heart Disease, ed. 4, Philadelphia, W. B. Saunders Company, 1951.
7. Wilson, M. G., and Helper, H. N.: Effect of pituitary adrenocorticotropin hormone (ACTH) in acute rheumatic carditis, J.A.M.A. 145:133–138 (Jan. 20) 1951.
8. a. Barnes, A. R., and others: Effect of cortisone and corticotropin (ACTH) on the acute phase of rheumatic fever, Am. J. Dis. Child. 82:397–425 (Oct.) 1951.
   b. Baty, J. M., Kreidberg, M B., and Swenson, O.: Medical progress: pediatrics, New England J. Med. 247:977–984 (Dec. 18) 1952.
9. Gray, S. J., Reifenstein, R. W., and Benson, J. A., Jr.: ACTH therapy in ulcerative colitis, regional enteritis, New England J. Med. 245: 481–487 (Sept. 27) 1951.
10. a. Doerner, A. A., and others: Development of tuberculous meningitis following cortisone therapy, Am. Rev. Tuberc. 64:564–571 (Nov.) 1951.
    b. Kleinschmidt, R. F., and Johnston, J. M.: Miliary tuberculosis in a cortisone treated patient; case report with autopsy, Ann. Int. Med. 35:694–702 (Sept.) 1951.
    c. King, E. Q., and others: Tuberculosis following cortisone therapy, J.A.M.A. 147:238–241 (Sept. 15) 1951.
    d. Popp, C. G., Ottosen, P., and Brasher, C. A.: Cortisone and pulmonary tuberculosis, J.A.M.A. 147:241–242 (Sept. 15) 1951.
    e. Fred, L., and others: Development of active pulmonary tuberculosis during ACTH and cortisone therapy, J.A.M.A. 147:242–246 (Sept. 15) 1951.
11. Kinsell, L. W.: The clinical application of pituitary adrenocorticotropic and adrenal steroid hormones, Ann. Int. Med. 35:615–651 (Sept.) 1951.
12. Irons, E. N., and others: ACTH and cortisone in diffuse collagen disease and chronic dermatoses; differential therapeutic effects, J.A.M.A. 145:861–869 (March 24) 1951.
13. Borman, M. C., and Schmallenberg, H. C.: Suicide following cortisone treatment, J.A.M.A. 146:337–338 (May 26) 1951.
14. Sprague, Randall, Mayo Clinic: Personal communication to the authors.

TABLE 1—*Results Obtained With ACTH and Cortisone*

Diseases	Drugs	Results: Excellent	Results: Good	Results: Poor	Number of Patients	
Arthritic Diseases						93
Rheumatoid arthritis	ACTH	4	15	2	21	
	Cortisone	11	12	1	24	
	Both drugs	10	10	2	22	
Osteoarthritis	ACTH	3	9	1	13	
	Cortisone		3		3	
	Both drugs	1	1		2	
Gout	ACTH	2	3	1	6	
	Cortisone	2		1	3	
	Both drugs					
Dermatologic Disorders						38
Exfoliative dermatitis	ACTH		2		2	
	Cortisone					
	Both drugs		1		1	
Contact dermatitis	ACTH	2			2	
	Cortisone		1		1	
	Both drugs					
Atopic eczema	ACTH	1	4		5	
	Cortisone	1			1	
	Both drugs					
Urticaria	ACTH	15	2		17	
	Cortisone	3			3	
	Both drugs	2			2	
Pemphigus	ACTH		2		2	
	Cortisone					
	Both drugs					
Neurodermatitis	ACTH					
	Cortisone	1	1		2	
	Both drugs					
Allergic Disorders						24
Asthma	ACTH	6	11	3	20	
	Cortisone		3	1	4	
	Both drugs					
Ophthalmologic Disorders						22
Iritis	ACTH	3	4		7	
	Cortisone		2		2	
	Both drugs					
Uveitis	ACTH					
	Cortisone	1	1		2	
	Both drugs					
Keratitis	ACTH					
	Cortisone					
	Both drugs	1	1		2	
Retrobulbar neuritis	ACTH					
	Cortisone			2	2	
	Both drugs					
Corneal ulcer	ACTH		1		1	
	Cortisone	1			1	
	Both drugs					
Chorioretinitis	ACTH		1		1	
	Cortisone					
	Both drugs					
Iridocyclitis	ACTH	1	1		2	
	Cortisone					
	Both drugs		1		1	
Avulsion of the eyeball	ACTH					
	Cortisone		1		1	
	Both drugs					
Hematologic Disorders						21
Acquired hemolytic anemia	ACTH		2		2	
	Cortisone					
	Both drugs					
Thrombocytopenic purpura	ACTH		3		3	
	Cortisone			1	1	
	Both drugs	1			1	
Monocytic leukemia	ACTH			1	1	
	Cortisone					
	Both drugs					
Chronic myelogenous leukemia	ACTH			4	4	
	Cortisone			2	2	
	Both drugs			1	1	
Erythroblastosis fetalis	ACTH		1		1	
	Cortisone					
	Both drugs					
Lymphatic leukemia	ACTH			1	1	
	Cortisone					
	Both drugs		1		1	
Hyperchromic anemia	ACTH					
	Cortisone					
	Both drugs		1		1	
Aplastic anemia	ACTH			2	2	
	Cortisone					
	Both drugs					
Collagen Diseases						14
Rheumatic fever	ACTH		2	1	3	
	Cortisone		1		1	
	Both drugs			1	1	
Dermatomyositis	ACTH		1		1	
	Cortisone					
	Both drugs	1		1	2	

(Continued on next page)

TABLE 1—*Results Obtained With ACTH and Cortisone (Continued)*

Diseases	Drugs	Results: Excellent	Results: Good	Results: Poor	Number of Patients	
Lupus erythematosus disseminatus	ACTH			1	1	
	Cortisone					
	Both drugs		1		1	
Periarteritis nodosa	ACTH			2	2	
	Cortisone					
	Both drugs					
Unclassified	ACTH			1	1	
	Cortisone	1			1	
	Both drugs					
Miscellaneous Disorders						12
Chronic ulcerative colitis	ACTH	1	1	1	3	
	Cortisone			2	2	
	Both drugs					
Multiple myeloma	ACTH		1	2	3	
	Cortisone			1	1	
	Both drugs			1	1	
Nephrosis	ACTH		2		2	
	Cortisone					
	Both drugs					
Mixed	ACTH	6	2	2	10	17
	Cortisone	3	3		6	
	Both drugs	1			1	
Total Number of Patients						241

TABLE 2—*Classification of Diseases According to Required Duration of ACTH or Cortisone Therapy*

Diseases which may respond to short-course therapy:

- Angioneurotic edema
- Arthritis, acute
- Asthma
- Beryllium poisoning, acute
- Burns
- Bursitis
- Dermatitis: exfoliative, acute eczema
- Drug reactions: e.g., penicillin sensitivity
- Eye: acute inflammatory diseases.
- Gouty arthritis
- Hay fever
- Jaundice, acquired hemolytic
- Nephrosis
- Poison ivy
- Rheumatic fever
- Serum sickness
- Shock
- Tenosynovitis
- Urticaria

Diseases requiring maintenance therapy in which

(a) response may be excellent:

- Hemolytic anemia, acute
- Pulmonary berylliosis
- Regional enteritis
- Rheumatoid arthritis
- Ulcerative colitis

(b) life may be temporarily prolonged:

- Dermatomyositis
- Disseminated lupus erythematosus
- Lymphatic leukemia

UNIVERSITY OF ILLINOIS SCHEDULES ASSEMBLY IN OTOLARYNGOLOGY

The Department of Otolaryngology of the University of Illinois College of Medicine recently announced the dates for its Annual Assembly in Otolaryngology. The program is divided in two sections of five days each. Applications for attendance may be made for one section only or for both.

The Basic Section, September 21 through 26, is under the direction of Dr. M. F. Snitman. It will be devoted to surgical anatomy and cadaver dissection of the head and neck and histopathology of the ear, nose, and throat.

The Clinical Section, September 28 through October 3, will consist of lectures and panel discussions, with group participation on otolaryngological problems and current trends in medical and surgical management.

For information regarding registration write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

The Treatment of Inguinal Hernia in Infancy and Childhood

By MARK T. O'MEARA, M. D., F. A. C. S.
La Crosse

THE question of when to operate for the treatment of inguinal hernia in young children is controversial. The optimum age has gradually been reduced in the past decade. Some authorities recommend deferring operative treatment until the infant is one to three years old. Ladd and Gross[1] advocate treating the hernia with a yarn truss and operating when the infant has reached the age of about 12 months. Babcock[2] states that treatment of inguinal hernia with a truss is curative in 60 per cent of patients under 3 years of age. According to Iason,[3] when a successful result with a truss seems unlikely after the age of 4 years, operations should be performed for reducible inguinal hernia. Nelson[4] advises surgical repair of inguinal hernias which persist through the second year of life. At one time it was customary to defer surgery until the child had been trained in toilet habits.

The work of Larsen[5] in 1949 threw an entirely new light on the subject of operative treatment of inguinal hernia in infancy. He says, "Operation should not be deferred because of the age of the patient. *The truss should not be employed in the treatment of inguinal hernia in infancy and early childhood.* The cures are rare. The danger of the hernia is not diminished. The fear of the hernia by the parent and the inefficacy and filth of the truss result in an environment that produces profound emotional disturbances in both the parents and the child."

Duckett[6] and Zimmerman[7] agree that inguinal hernia should be repaired surgically at the time of diagnosis regardless of age.

Our attention was drawn to this question rather forcibly in 1950 when a young mother presented her 7½ month old male infant, who had a left inguinal hernia. The mother rebelled against the use of a truss. She herself had an inguinal hernia during childhood and had worn a truss until the age of puberty. She felt that the psychic trauma of having to wear a truss had been severe in her own particular case. She did not want her child to go through a similar experience. Consequently, a surgical procedure was performed on the infant at the age of 7½ months. When the infant was 11 months an inguinal hernia developed on the opposite side and was repaired immediately.

Since this experience, we have performed surgical repairs of inguinal hernia on 10 infants at the time of the diagnosis. The youngest patient was a female infant 7 weeks of age with an incarcerated right inguinal hernia. During surgery the right ovary and fallopian tube were found to occupy the hernial sac when an emergency operation was performed. This series included two elective operations on female infants, aged 4 months and 11 months respectively. In both these patients the ovary and tube were encountered. Each patient withstood the procedure well and both the parents and children benefited by not having to be afflicted with a truss.

Ladd and Gross[1] summarize the embryology of inguinal hernia as follows: "Inguinal hernia in the child is almost invariably of the indirect type and represents a persistence of the fetal condition in which the peritoneum has an outpocketing along the inguinal canal. In embryonic life the testis develops high on the posterior wall of the abdomen, whence it gradually descends to its final resting place in the scrotum. This migration is apparently initiated and facilitated in some poorly understood way by the gubernaculum, a mass of tissue containing smooth muscle which is attached to the lower pole of the testicle.

"Before the testis enters the inguinal canal the processus vaginalis projects down from the peritoneum through the various muscle and fascial planes but still retains a communication with the general peritoneal cavity. The fully descended testicle comes to rest alongside of this sac, the lowermost bit of which is pinched off to form the ensheathing tunica vaginalis. The upper part of the processus vaginalis normally atrophies, but if it does not do so the sac remains as a congenital indirect inguinal hernia. If the entire processus remains patent, then the resulting hernia extends downward as far as the lower tip of the testicle.

"The right testicle descends at a somewhat later date than does the left and accordingly the right processus vaginalis is closed off at a later time than is the left one. This delayed series of events—when accentuated—probably accounts for the greater frequency of congenital indirect inguinal hernia on the right.

"In the female, the processus vaginalis develops in a similar manner and can persist into postnatal life. The hernial sac is contiguous with the round ligament of the uterus."

The type of operation for repair of inguinal hernia in infants should be a simple herniotomy with sac ligation only. A small skin incision is made. The external oblique fascia is opened over the internal inguinal ring and, in most cases, the external ring is not opened. The hernial sac is dissected free and ligated high at its base. One suture at the internal ring will suffice and the wound is closed in layers. A subcuticular suture of plain chromic No. 0 catgut is used in the skin. This is done to avoid the necessity of removing skin sutures. Admittedly, the surgical technic is more difficult in the repair of hernia in infants. It is comparable to the repair of the Swiss watch as opposed to the repair of Big Ben.

We believe surgical repair should be advised for the inguinal hernia in infancy at the time the diagnosis is made, provided the infant is in satisfactory condition for general anesthesia.

1707 Main Street.

REFERENCES

1. Ladd, W. E., and Gross, R. E.: Abdominal Surgery of Infancy and Childhood, "Inguinal Hernia," Chap. 29, pp. 354–366, Philadelphia, W. B. Saunders Company, 1941.
2. Babcock, W. W.: Principles and Practice of Surgery, Philadelphia, Lea and Febiger, 1944.
3. Iason, A. H.: Hernia, Philadelphia, The Blakiston Company, 1941.
4. Nelson, W. E., ed.: Mitchell-Nelson Textbook of Pediatrics, ed. 4, Philadelphia, W. B. Saunders Company, 1945.
5. Larsen, R. M.: Inguinal hernia in infancy and early childhood, Surgery, 25:307–328 (Feb.) 1949.
6. Duckett, J. W.: Treatment of congenital inguinal hernia, Ann. Surg. 135:879–885 (June) 1952.
7. Zimmerman, L. M.: Recent advances in surgery of inguinal hernia, S. Clin. North America, 185–153 (Feb.) 1952.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1953 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Unless otherwise directed, forms for the purpose of referral may be obtained from the Bureau for Handicapped Children, and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined so that plans may be made for the required personnel.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and, if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of this fact.

Lancaster	July 9
Darlington	July 10
Eau Claire	July 16, 17
Ashland	August 13, 14
Wausau	August 26, 27
Manitowoc	September 2, 3
Marinette	September 9
Kenosha	September 16, 17
Green Bay	September 24, 25
Superior	September 30, October 1
Racine	October 8, 9
La Crosse	October 13, 14, 15, 16
Sheboygan	October 29, 30
Chippewa Falls	November 3, 4
Rhinelander	November 11, 12
Eau Claire	November 19, 20
Appleton	November 23, 24
Fond du Lac	December 2, 3

Inquiries concerning these clinics may be addressed to the Bureau for Handicapped Children, Room 146 North, State Capitol, Madison 2, Wisconsin.

Some Epidemiologic Aspects of Poliomyelitis in Wisconsin, 1947-1952*

Their Relation to Gamma Globulin Distribution and Value in Epidemic Control

By MILTON FEIG, M. D.
Madison

THE availability of a limited supply of Red Cross gamma globulin for use in the prophylaxis and modification of poliomyelitis has focused the attention of the medical profession and public on this disease to a greater degree than ever before. Questions and interest have been raised on the previous incidence of poliomyelitis in Wisconsin, the clinical value and use of gamma globulin in this disease, and the expected results of its use both clinically and in epidemic control. This paper will be an attempt to present some pertinent facts and answer some of the questions.

The Incidence of Poliomyelitis

The reported incidence of poliomyelitis during the years 1947 through 1952 is shown in Chart 1. During this 6 year period the number of reported cases has risen more than tenfold—from 206 cases in 1947 to 2,213 cases in 1952. With the exception of 1950, this rise has been progressive and significant. The question whether the rise in reported cases during this period represents a true rise in the incidence of the disease or is merely a result of more accurate diagnosis or better reporting on the part of physicians has been answered on a national level, where a similar increase of incidence has been noted. All authorities seem to agree that though improved awareness, diagnosis, and reporting on the part of physicians are an important factor the rise in reported cases represents a true rise in incidence as well.

Since the basic allocation of gamma globulin to the states is determined by the average number of cases reported during the five year period 1947–1951, this is depicted in Chart 1 by the dotted bar. The average number of such reported cases is 849. In view of past experiences with the incidence of poliomyelitis within the state, it would seem conservative to estimate that a minimum of 3,000 cases might be reported this year. We must remember, however, that such predictions of epidemic severity are subject to exception and error.

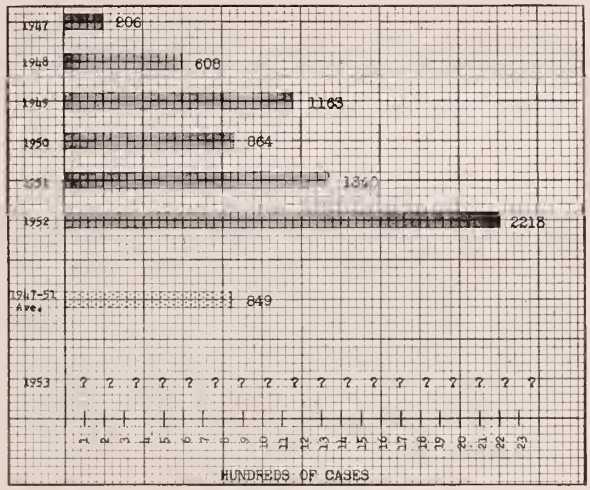


CHART 1—*Reported Cases of Poliomyelitis (1947–1952)*

The Seasonal Variation in Incidence

Chart 2 shows the annual incidence of poliomyelitis according to month of onset. It will be noted that few or no cases have their onset during the first 5 months of the year, January through May. During 1947 and 1948, the same applied for the month of June. Beginning with 1949, however, a slight increase in the number of cases is noted during June, varying from about 20 cases in 1949, 1950, and 1952 to about 50 cases in 1951. It is obviously impossible to predict the possible severity of an epidemic from the number of cases reported during June (see years 1951 and 1952) and even during the month of July (compare years 1948 and 1950; and years 1951 and 1952).

The maximum monthly incidence was reached during the months of September in

* Presented before the joint meeting of the Wisconsin Society of Pathologists and the Wisconsin Association of Blood Banks, Marshfield, May 16, 1953.

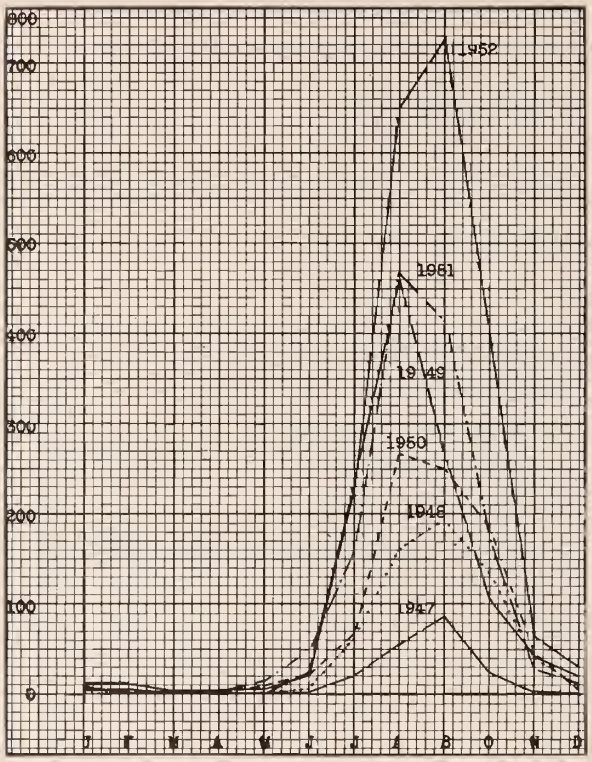


CHART 2—*Incidence of Poliomyelitis by Month of Onset (1947–1952)*

1947, 1948, and 1952 and August in 1949, 1950, and 1951. In one instance after a peak incidence was reached in August, there was a marked drop in September (see 1949), but in most instances there was a tendency towards a flattening of the incidence curve, maintaining proximity to the maximum peak, as for the years 1950 and 1951. During 1947, 1948, and 1952, maximum disease incidence occurred in September, although the second highest monthly incidence for those same years occurred in August. *It is thus obviously impossible to predict the nature of the epidemic curve even in August.* The only consistent factor lending aid to epidemic predictability in poliomyelitis is that there is a rapid drop in October, so that the incidence in this month usually parallels that of July, the incidence of November for each year resembles that of June, and December that of May. From the Wisconsin data, the curve of monthly distribution of onset seems to resemble that of a normal curve distribution. For the nation as a whole, the peak incidence seems to occur in July and August in the Southern states, August and September in the Midwestern and Pacific states, and September and October in the Northeastern states.

The Seasonal Distribution of Paralytic and Non-Paralytic Cases

During the 5 year period 1947–1951, an average of 460.2 paralytic and 332.2 non-paralytic cases was reported. This ratio is as expected—about 60 per cent (58.1) paralytic to 40 per cent (41.9) non-paralytic cases. This ratio is also true of 1952, when 1,083 paralytic (57.1 per cent) and 816 non-paralytic (42.9 per cent) cases of poliomyelitis were reported. Not included are less than 40 cases in the first group, and less than 100 cases in the second group, for which no data on paralytic status was available.

Of interest should be the proportion of paralytic to non-paralytic cases reported as the epidemic progresses and wanes. This is depicted graphically in Chart 3, for the months May through November. The number of cases for the omitted months, and May as well, is too small for comparative purposes. At the start of the season, say June, 56 per cent of reported cases are paralytic. In July, this rises to 61 per cent paralytic. Then, as the season reaches its height

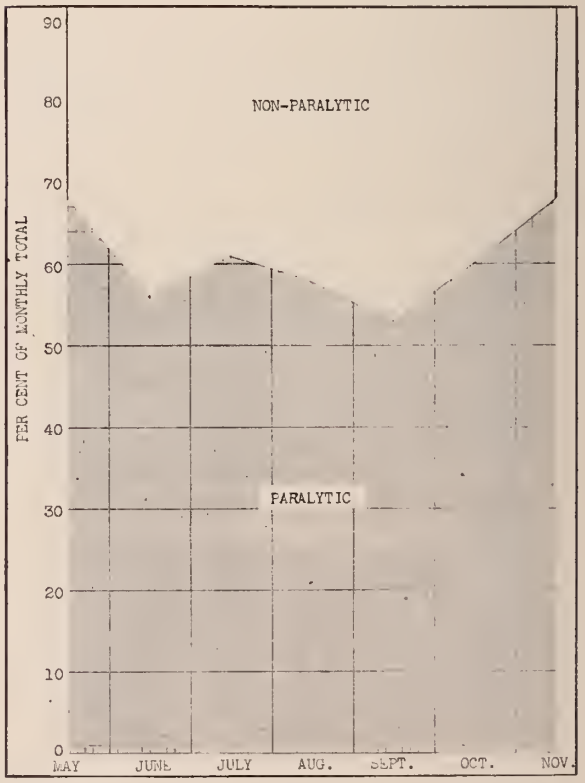


CHART 3—*Percentage Distribution of Paralytic and Non-paralytic Poliomyelitis by Month, May 1–December 1, Five Year Average (1947–1951)*

in August and September, the percentage of paralytic cases decreases to 58 and 53 respectively. This is a signficant decrease for the large number of cases occurring during these months. Finally, as the epidemic declines, the percentage of paralytic cases reported increases to 60 in October and 68 in November. The probability of an increased awareness by the physician to the disease during the months of greatest severity might account for the increased proportion of non-paralytic cases reported at such periods.

Averages of the 5 year period 1947–1951 show that 60 per cent (499) of all cases (832) occurred during the two months of August and September. The same proportion is obtained for 1952. Moreover, 60 per cent of all paralytic cases were reported during these two months.

When we consider the cases reported during the 4 month period July through October, we find that 85 per cent of the reported average (711 of 832 cases) occurred during this time. But during this interval 90 per cent of all paralytic cases were reported. Here again is evidence of the reporting of proportionately more non-paralytic cases during the months of highest epidemicity.

Age Distribution of Cases and Household Contacts

Table 1 shows the age distribution of poliomyelitis cases in Wisconsin for the 3 year period 1948–1950, and the age distribution of household contacts to cases during the 5 year period 1947–1951.

Seventy-eight per cent of all cases reported in Wisconsin were 19 years of age and under. Fifty per cent of all cases were under 10 years of age, of which 22 per cent were in the 0–4 year age group. Twenty-eight per cent of all cases were in the 5–9 year group, the percentage of such cases exactly equaling the 10–14 and 15–19 age groups combined.

Twenty per cent of all household contacts to poliomyelitis cases were in the youngest (0–4 year) age group. Thereafter there is a uniform decrease by 5 per cent in the percentage of each successive contact group involved to age 20, so that only 5 per cent of all contacts were in the age group 14–19.

Of great interest should be the comparison of the percentage ratios of contacts to cases as a possible estimate of the risk attack rate. The ratios of case percentage to household contact percentages are 1 to 1 (22 to 20) in the 0–4 age group, 2 to 1 (28 to 15) for the 5–9 group, and 2 to 1 for the age groups 10–14 and 15–19 (17 to 10 and 11 to 5.5 respectively). This ratio is reversed to 1 to 2 in the 20 year and over age group (22 per cent of cases and 48 per cent of household contacts).

Based on these data the risk ratio in contact individuals is one fourth as great in those over 20 as in those under 20 years of age. The equal ratio in the 0–4 age group is undoubtedly influenced by the apparent transplacental immunity exhibited by infants in the first year of life.

The Value of Gamma Globulin as a Prophylactic and Modifying Agent in Poliomyelitis

In 1952, in field trials conducted in epidemic areas in Utah, Texas, and Iowa–Nebraska, Hammon[1] conclusively demonstrated the value of gamma globulin in poliomyelitis prevention. Table 2 is a modification of one of Hammon's tables showing the effectiveness of approximately 27,500 immunizing doses of gamma globulin, compared with the number of cases occurring in a similar control group of children (through 11 years of

TABLE 1—*Poliomyelitis in Wisconsin—Age Distribution of Cases (1948–1950) and Contacts (1947–1951)*

Age	Cases—3 Years 1948–1950			Contacts—5 Years 1947–1951		Percentage Risk Attack Rate
	Number	Per Cent		Number	Per Cent of All Contacts	
		Of All Cases	Cumulative			
0–4	585	22	22	3,293	20	1–1
5–9	747	28	50	2,479	15	2–1
10–14	450	17	67	1,608	10	2–1
15–19	275	11	78	905	5.5	2–1
20+	576	22	100	7,918	48	1–2
No Data Age	10			275	1.5	
Total	2,643	100.0	100.0	16,478	100.0	

Note: (1) In the five year period 1947–1951 Wisconsin had 4,181 cases of polio reported. In that same period we had 16,478 contacts—a ratio of 3.9 contacts per case.
(2) Risk in age group 20 and over is one quarter that of the 20 and under age groups.

TABLE 2—*Number of Cases of Paralytic Poliomyelitis among Inoculated Children in Three Study Areas, by Place, by Type of Inoculum, and by Week after Inoculation*

Weeks After Inoculation	Utah, Texas, and Iowa–Nebraska Areas Combined				
	27,500 G.G.	27,500 Gelatin	Total	Gamma Globulin, %	p
1	12	16	28	42.9	>0.3
2	3	24	27	15.2	<0.001
3	3	8	11		
4	1	4	5		
5	0	3	3		
6	3	4	7	35.0	>0.1
7	3	6	9		
8	1	3	4		
9	4	1	5		
10	0	1	1	50.0	----
11	1	0	1		
12	0	2	2		
13	0	1	1		
2–13	19	57	76	25.0	<0.001
Total	31	73	104	29.8	<0.001

Modified from Hammon, J.A.M.A., 151:1277, April 11, 1953.
p = probability.

age) who received gelatin injections only. The average epidemic rate in these areas was slightly above 4 cases per thousand population.

Thirty-one cases of poliomyelitis occurred in the gamma globulin-injected group as compared with 73 in the control group—a decrease of 42 cases. This is a highly significant decrease; the probability of such a difference occurring by chance is less than 1 in 1,000. Another way of expressing this result is by stating that, at an epidemic rate of 4 cases per thousand population, 1,000 immunizing doses of gamma globulin prevented 1½ cases.

It will be observed from the table that the only significant protective effect among those receiving gamma globulin occurred in the second through fifth weeks after injection. After the fifth week the protective value was lost, so that during weeks 6, 7, and 8, 35 per cent of all the cases occurred in the immunized group, and thereafter 50 per cent of all poliomyelitis cases. Nor was any significant preventive effect noted in the first week after injection.

The study group did find, however, that of those cases of poliomyelitis which occurred in immunized children during the first week after immunization, both the extent and severity of paralysis was modified greatly. Of the 12 cases so occurring, none had any residual paralysis beyond a grade so light that it would in all likelihood have been considered a non-paralytic case. This modifying effect was not appreciably evident in the cases occurring in the immunized children after the first week.

That gamma globulin is of no value in treatment after onset is already well established.[2]

Consideration of Red Cross Gamma Globulin Distribution in Wisconsin

The gamma globulin used by Hammon and associates in their field trials and found effective in the prophylaxis and modification of poliomyelitis was obtained from Red Cross blood banks formed by contributions from large groups of people. It was proved to have an adequate quantity of antibodies for the three known strains of poliomyelitis viruses. This has not been shown to be true of placental gamma globulin or of that formed from whole blood obtained from small groups of human beings. The Red Cross gamma globulin, tested for poliomyelitis virus antibody content, is distributed by the Office of Defense Mobilization to the state health departments. Using 7 cc. as the average dose (50 lb. child at 0.14 cc. per pound) it is estimated that nationally there is one dose for every 40 to 45 children under 16 years of age. The Wisconsin basic allotment, based on 60 cc. times the average number of cases (849) reported during the 5 year period 1947–1951, is 50,940 cc.

It was necessary to comply with the recommendations of the Office of Defense Mobilization for the use of the gamma globulin. These recommendations have been accepted by the Blood Bank Committee of the State Medical Society and the State Board of Health. They have been published in a previous issue of this Journal.[3] While the use of this basic allocation is restricted to household contacts (living in the same home) of clinically diagnosed acute cases, it was necessary for the Committee to determine in what age groups the limited supply should be used. The chief factors involved in such consideration and the ultimate decision reached are shown in Table 3.

In brief, the pertinent factors are as follows:

1. Fifty per cent of all household contacts to previously diagnosed cases were 19 years of age and under.

2. The risk in this age group was 4 times as great as in the older age groups, 20 and over.

3. Though it is of course impossible to make an accurate prediction, there seems

every likelihood based on previous experience that the number of reported poliomyelitis cases for 1953 will exceed the 2,213 reported for 1952, and will probably approach 3,000 cases.

4. The basic supply of gamma globulin (50,940 cc.) will be scarcely adequate to protect those under 20 years of age who are household contacts to this estimated number of cases. Protecting these contacts would require 51,274 cc. based on 3.9 contacts per case, percentage age distribution of contacts, and their estimated weights times 0.14 cc. These calculations do not include distribution for use in pregnant women regardless of age who might also be household contacts.

5. Quantities required to immunize a single individual in the lower-risk older age group would be adequate to immunize about 3 average children (20 cc. versus 7 cc.).

6. While, on the national level, there will be one average immunizing dose for every 40 to 45 children 15 years of age and under, the basic quantity Wisconsin will receive represents about 7,300 immunizing doses, or one for every 127 children in this age group. If used in age group 19 and under (as determined), then there is one dose for every 146 children.

Probable Effect of Gamma Globulin in Epidemic Control

In 1952, the year of greatest poliomyelitis incidence in Wisconsin, the attack rate was 0.6 per thousand. The average attack rates in the areas studied by Hammon and his group was 4.2 per thousand. This attack rate is almost never reached in large cities or on a state-wide level. It is obvious that the number of cases that might be prevented or modified in an epidemic with a given quantity of gamma globulin would depend, to a great degree, on the severity of the epidemic. Thus, if 1,000 children were immunized in an area with an attack rate of 1 per thousand population, then the thousand doses could not be expected to prevent more than 1 case.

In Hammon's field trials, and at an average attack rate of 4.2 per thousand, 1.5 cases were prevented with 1,000 doses. At last year's epidemic rate in Wisconsin, one seventh that of the field trials, 0.2 cases per 1,000 doses would be prevented in children under 15, and with 7,300 available doses, it might be estimated that no more than 1 to 2 cases would be prevented. Instead of 2,213 reported cases we would have 2,211 cases.

Let us assume that in 1953 Wisconsin will have a poliomyelitis epidemic of 1 case per thousand population, a rate almost twice that of 1952, a record year. At such a rate, 3,688 cases of poliomyelitis would be reported. Then the 7,300 available doses, used in children under 16, would be expected to prevent about 0.4 cases per thousand doses, or a total of 3 cases prevented and probably 1 case modified. In such an event, the number of cases reported would be 3,685 instead of 3,688.

The above estimates were based on general use of gamma globulin as used by Hammon; *i.e.*, in children selected at random during an epidemic. However, it is well known that household attack rates are 5 to 20 times greater than those of the general population.[2] Since the basic allocation of gamma globulin will be used only for household contacts to diagnosed active cases, the possible value in epidemic control with such use for the available supply can be estimated. I should like to make the estimation on the basis of the most

TABLE 3—*Anticipated Gamma Globulin Needs for Poliomyelitis*

Age Group	Per cent of Contacts (1947–51 Averages)		Ave. Wt. of Contacts	G.G. Required per Ave. Contact (.14 cc./lb.)	Anticipated Needs			
					With 2,000 Cases		With 3,000 Cases	
	In Group	Cumulative			No. of Contacts (3.9 per case) (1947–1951)	G.G. in cc.	No. of Contacts (3.9 per case)	G.G. in cc.
0– 4	20	20	30	4.2 cc.	1,600	6,720	2,400	10,580
5– 9	15	35	50 (51)	7.0 cc.	1,200	8,400	1,800	12,600
10–14	10	45	90 (88)	12.6 cc.	800	10,080	1,200	15,120
15–19	5.5	50.5	135	18.9 cc.	440	8,316	660	12,974
TOTAL	50.5	50.5			4,040	33,516	6,060	51,274
20–29	14.6*	65.1		20.0 cc.	1,168	23,360	1,752	35,040
TOTAL		65.1			6,208[a]	56,876	7,812[a]	86,314

*Based on population age distribution.
[a]Does not include pregnant women of any age.

favorable effect to be expected. This might be with an assumed rate of 1 per thousand; *i.e.*, 3,688 cases for 1953. Let us also accept the highest household attack rate in this epidemic; *i.e.*, 20 per thousand population (5 times that of Hammon's study). Then 1,000 doses used in household contacts would probably prevent 7.5 cases, and 7,300 doses so used would prevent 55 cases. About 60 cases would be modified. But even with these assumptions, made with the desire to obtain maximum use and effectiveness, the epidemic case reports would show 3,633 cases instead of 3,688.

There can be no doubt that with the most logical use of the present available supply of gamma globulin, even several times such supply, there would be very little effect, if any, on the size of the epidemic of poliomyelitis during the current year, and on the total number of cases.

Summary

1. With the exception of one year, there was a progressive tenfold increase in the incidence of reported cases of poliomyelitis in Wisconsin during the 6 year period 1947–1952, with 206 in 1947 and 2,213 in 1952.

2. The peak incidence of poliomyelitis is characteristic of the midwestern picture, the peak being reached during August or September. It has been impossible to predict the course of epidemic poliomyelitis from cases reported in June, July, or August.

3. About 60 per cent of all cases reported are paralytic, 40 per cent non-paralytic. There is an increase in the proportion of non-paralytic cases reported during the months of highest epidemicity.

4. Fifty per cent of all reported cases were 9 years of age and under; almost 80 per cent were 19 years of age and under.

5. Fifty per cent of all household contacts to reported cases were 19 years of age and under. Of this, 20 per cent were in the 0–4 year age group.

6. The percentage risk attack rates in the group under 20 years of age (except 0–4 years) was 4 times higher than in those 20 years of age and over.

7. The value of gamma globulin as a preventive and modifying agent in poliomyelitis is discussed.

8. The factors considered in determining age limitations for the use of the available supply of gamma globulin to Wisconsin are presented.

9. The present supply of gamma globulin, even with most effective use, will have no appreciable influence on the epidemic incidence of poliomyelitis in 1953.

State Board of Health.

REFERENCES

1. Hammon, W. McD., Coriell, L. L., Wehrle, P. F., and Stokes, J., Jr: Evaluation of Red Cross gamma globulin as a prophylactic agent for poliomyelitis; final report of results based on clinical diagnoses, J.A.M.A. 151:1272–1285 (April 11) 1953.

2. Statement of National Research Council, Division of Medical Sciences. "The Distribution of Gamma Globulin." April 20, 1953.

3. Gamma globulin and poliomyelitis; a statement of policy and procedures of distribution, Wisconsin M.J. 52:223–224 (April) 1953.

CHEST FILM ENLARGEMENTS AVAILABLE

The Wisconsin State Board of Health, in response to a suggestion by the Chest Committee of the State Medical Society, announces that it is prepared to furnish, on request by physicians, copies or enlargements of 70 mm. films taken of their patients in mobile unit surveys throughout the state.

In order to expedite such service the State Board of Health will also serve as a clearing house to locate films taken by other agencies which operate independent units.

Physicians desiring such information or films should communicate with:

Division of Tuberculosis Control
Wisconsin State Board of Health
1 West Wilson Street
Madison 2, Wisconsin

Congenital Esophageal Atresia with Tracheo-Esophageal Fistula and Associated Pectus Excavatum, Prematurity, and Right Aortic Arch

Case Report of Surgery with Recovery*

By WILSON WEISEL, M. D., and GILBERT DEDINSKY, M. D.
Milwaukee Smock, Pa.

THE number of successful corrections of the otherwise fatal congenital esophageal atresia reported in the literature has gradually increased since the original descriptions of this outstanding surgical triumph.[1-3] At the same time the large number of disappointments in store for surgeons handling the infants presenting these problems has been just as frequently and graphically described.[4-8] One of the reasons for the persistent high mortality in the operative corrections of these abnormalities has been the presence of other congenital deformities which have had decidedly unfavorable influences on the eventual outcomes of some of the patients.

The authors believe, however, that the fact that an occasional individual patient is given an opportunity for a normal life in the face of what appear to be insurmountable difficulties should also be pointed out. It is hoped that the recounting of this case will serve as an additional stimulus in the efforts to secure accurate early diagnoses of congenital defects and therefore to obtain the best treatment for these patients.

Case Report

CASE 8189**—R. H. was a premature girl infant born of a 37 year old white mother on July 11, 1952, about one month before the predicted confinement date. Labor was uneventful and breathing began immediately after birth, but the respirations were extremely labored and the baby was cyanotic. There was a marked retraction of the sternum and the respiratory movements were very shallow and jerky. The child was placed in an oxygen tent at once and later transferred to an "air-lock" apparatus. The baby was noted to have considerable drooling of thick secretions from the mouth, an occasional weak, husky cry, and a rare cough.

On July 12, when an attempt was made to pass a catheter down the esophagus, a block was encountered about 10 cm. from the gum margin. Roentgenograms were then made which confirmed the presence of an esophageal atresia of the type 3b as described by Vogt.[9] (Fig. 1) In addition, atelec-

Fig. 1—Roentgenogram of patient's chest, showing Lipiodol filled proximal atretic esophageal pouch, right upper lobe atelectasis, and air in the gastrointestinal tract.

* From the Surgical Service, St. Joseph's Hospital and the Marquette University School of Medicine.

** Referred by Dr. Paul A. Lee, Milwaukee, Wisconsin.

tasis of the right upper lobe was seen radiologically and, as noted above, the diagnoses of prematurity and pectus excavatum were also made. At the time of this examination the baby's weight was 3 lb. 14 oz. (1,757 Gm.); the rectal temperature 101 F.; and her condition appeared poor.

The child was treated vigorously with frequent pharyngeal aspirations, two tracheal aspirations, parenteral penicillin, vitamins C and K, subcutaneous fluids, and constant oxygen therapy. About 48 hours after birth the child was felt to have attained maximum improvement and she was taken to surgery. As an initial procedure a polyethylene tube was placed in the left saphenous vein for administration of blood and fluids.

The patient was anesthetized by Dr. George C. Kreuter and an endotracheal tube inserted. With the child in a left lateral decubitus position, a right thoracotomy was performed through a posterolateral incision entering the pleural cavity through the fifth intercostal space. As the lung was partially deflated and displaced posteriorly by hand it was obvious that the sternum was displaced posteriorly to within one inch of the vertebral column and caused rotation of the heart to the left. The sternum was pliable, but pressure anteriorly on its posterior surface caused no movement because of a heavy band in the diaphragm which ran from the lower sternum to the right of the lower thoracic vertebrae. This band, which was about 1.25 cm. thick and 2.5 cm. long, was divided posteriorly and the sternum was then easily pushed forward. Concomitant with this maneuver, which greatly increased the antero-posterior diameter of the chest, the anesthetist stated that assisted respiration was easier and the patient's color improved.

Through an incision in the mediastinal pleura from the azygos vein to the diaphragm, the lower esophageal segment was isolated and found to connect with the trachea posteriorly and above the carina. Just above this junction a large vascular structure coursed from the left chest down the right mediastinum to enter the abdomen just medial to the previously described diaphragmatic band. Dissection and retraction of this structure, which was necessary to work on the esophagus, revealed it to be a right-sided aorta.

The distal esophageal segment was then separated from the trachea and the tracheal opening was closed with interrupted 00000 silk sutures. The proximal esophageal segment was isolated and mobilized by freeing it from the azygos vein and dissecting the pouch to the thoracic inlet. In order to approximate the two esophageal segments the lower segment was mobilized further by clearing it of surrounding adventia almost down to the diaphragm. The upper opening of the lower segment was then opened obliquely and the upper segment pouch transversely so that the two ends more nearly approximated one another in size. The two esophageal segments were then anastomosed with a single row of interrupted 00000 silk sutures. The mediastinal pleura was left open. The lung was completely inflated and the chest was closed in anatomic layers with interrupted 0000 cotton sutures. Pleural drainage was secured by two catheters connected to subaqueous bottles.

Postoperatively the baby was given oxygen intermittently by a cone mask. In addition she received parenteral penicillin and intravenous solutions. The pharynx was aspirated at frequent intervals and the trachea was aspirated on three occasions; the child was turned on a regular schedule. In about 18 hours the respiratory tract seemed dry and the patient's respirations were considerably better than they had been before the operation. The rectal temperature 36 hours postoperatively was 99.8 F., and it remained at this level during her convalescence.

Four days postoperatively, on July 17, the baby was given a swallow of Lipiodol and its course was studied radiologically. (Fig. 2) Because of the satisfactory appearance of the anastomosis and the progress of the patient, oral fluids were begun and the polyethylene tube was removed from the leg vein. In two days the patient was given a weak milk formula and had developed a lusty cry.

The wound appeared well healed on July 20, seven days postoperatively, and the skin sutures were removed. The child's weight gradually increased to 6 pounds (2,721 Gm.). She was discharged to her home on August 12 on a normal milk formula. In addition, the baby's color, the chest contour, and the respiratory movements were normal. (Fig. 3)

Fig. 2—Lipiodol esophagram taken four days postoperatively, showing slight narrowing at the esophageal anastomosis but otherwise normal esophagus.

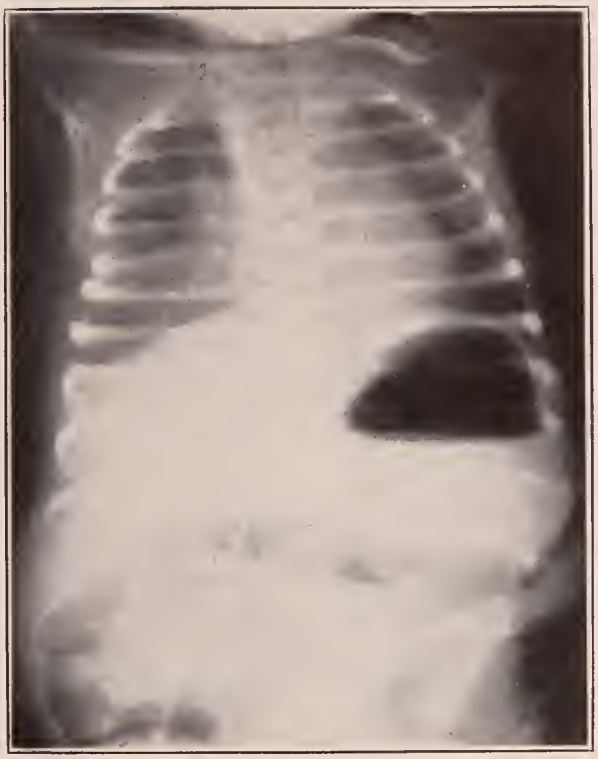


Fig. 3—Roentgenogram of chest made 22 days after operation showing normal expansion of both lungs.

On September 19 re-examination showed the baby's weight to be 8 pounds. At this time she had a slight cough during and after eating, but her appetite was excellent and she demonstrated a good cry. An esophagram showed what appeared to be a normal esophagus. Her progress continued to be normal, and on Jan. 7, 1953, her weight was 14 pounds (6,360 Gm.). It is expected that her satisfactory course will continue.

Discussion and Summary

Although a successful surgical technic has been developed and utilized for the handling of congenital esophageal atresia the mortality rate for infants with this disorder has remained at a high level. Of the many complex factors which have been considered to have an unfavorable influence on the results in these patients, one has been the presence of associated congenital abnormalities.

It is encouraging in the face of a pessimistic situation to learn of a successful result and conclusion. For that reason we have discussed the case of a patient presenting congenital esophageal atresia with tracheo-esophageal fistula, prematurity, pectus excavatum, and right aortic arch who responded favorably to surgical therapy.

(W.W.) 324 East Wisconsin Avenue.

REFERENCES

1. Haight, C., and Towsley, H. A.: Congenital atresia of the esophagus with tracheoesophageal fistula, Surg., Gynec. & Obst. 76:672–688 (June) 1943.
2. Ladd, W. E.: The surgical treatment of esophageal atresia and tracheoesophageal fistula, New England J. Med. 230:625–637 (May 25) 1944.
3. Leven, N. L.: Congenital atresia of esophagus with tracheoesophageal fistula, J. Thoracic Surg. 10: 648–657 (Aug.) 1941.
4. Bigger, I. A.: The treatment of congenital atresia of the esophagus with tracheoesophageal fistula, Ann. Surg. 129:572–587 (May) 1949.
5. Haight, C.: Congenital atresia of the esophagus with tracheoesophageal fistula, Ann. Surg. 120: 623–655 (Oct.) 1944.
6. Ladd, W. E., and Swenson, O.: Esophageal atresia and tracheoesophageal fistula, Ann. Surg. 125: 23–40 (Jan.) 1947.
7. Potts, W. J.: Congenital atresia of the esophagus with tracheoesophageal fistula, J. Thoracic Surg. 20:671–680 (Nov.) 1950.
8. Sweet, R. H.: A new method of restoring continuity of the alimentary canal in cases of congenital atresia of the esophagus with tracheoesophageal fistula not treated by immediate primary anastomosis, Ann. Surg. 127:757–768 (April) 1948.
9. Vogt, E. C.: Congenital esophageal atresia, Am. J. Roentgenol. 22:463–465 (Nov.) 1929.

Proceedings of the Milwaukee Academy of Medicine, April 21, 1953

Clinical Aspects of Ovarian Tumors*

By WILLIAM F. MENGERT, M. D.
Dallas, Texas

WHAT do we mean by ovarian tumor? Obviously it is necessary to differentiate between a neoplasm and a physiologic deviation cyst. This is relatively simple, because a physiologic deviation cyst seldom reaches a size larger than that of a tennis ball. Therefore, if one finds a cystic mass in the adnexal region of a woman in active menstrual life he should postpone interference and have a colleague examine her. He should also reexamine her in approximately a month. If the cyst has grown, or if it has not disappeared, then there is reasonable likelihood that one is dealing with a true neoplasm rather than with a physiologic deviation cyst. There are no solid physiologic ovarian masses. Therefore, the finding of a solid mass in the adnexa always suggests ovarian neoplasia.

True neoplasms of the ovary are uncommon. About 95 per cent of them are cystic and 5 per cent solid. Roughly—*very roughly*—about one third of ovarian neoplasms are dermoid cysts; another third represent cystadenoma of the simple, serous, or pseudomucinous variety. The remaining third include all other varieties of ovarian neoplasms. Two thirds of this last group (about 25 per cent of all ovarian tumors) are malignant.

Symptoms

Ovarian tumors produce few symptoms and are generally silent. Several common misconceptions have grown up around their symptomatology, among them the idea that menstrual aberrations and pelvic pain are common. Neither is the case, since the only menstrual aberrations due to ovarian neoplasia arise from the rare group of dysontogenetic tumors of which granulosa cell, theca cell, and arrhenoblastoma are examples. Pelvic pain occurs only if an accident happens to the tumor. Torsion of the pedicle may occur at any time, but usually when the patient is undergoing more than average exertion. There is no relation of torsion to the menstrual cycle. Generally speaking, tumors the size of a grapefruit or smaller are the ones that twist. The blood supply of the tumor is interfered with by twisting and edema; peritoneal irritation and pain ensue. These reach an acme in several hours, only to disappear later. The whole episode generally takes place in 5 to 10 hours. The patient recovers only to have another episode a day, a week, or three weeks later. There is no rhythmicity in the timing of episodes of twisting. The initial torsion seldom creates a surgical emergency.

One of the most important symptoms of ovarian tumor is mass. However, a mass the size of a baby's head may be contained completely within the true pelvis without giving any palpatory findings abdominally.

The finding of a mass on pelvic examination is the best way to make a diagnosis. This mass must, however, be differentiated from ectopic pregnancy, pelvic inflammatory disease, pedunculated myoma, and rarely from some of the more esoteric situations such as bicornate uterus.

The differentiation between a large ovarian tumor with encapsulated fluid and ab-

TABLE 1—*Differentiation Between Ascites and Cyst*

	Ascites	Ovarian Cyst
Abdominal contour	Symmetrically rounded	Rounded below umbilicus, flat above
Shifting dullness	Yes	Not often
Percussion		
Flanks	Dull tympany, (intestines float)	Often tympany dull, intestines squeezed lateral and superior
Anterior (around umbilicus)		
Superior (below xiphoid)	Dull	Tympany

* From the Department of Obstetrics and Gynecology of Southwestern Medical School of The University of Texas.

dominal ascites depends upon abdominal contour, percussion, and palpation.

Table 2 shows the most probable type of tumor to be found in the various age groups of life.

TABLE 2

Age	Solid	Cystic
Adolescent	Dysgerminoma	Dermoid
Active menstrual life (3rd-4th-5th decades)	Adenocarcinoma Fibroma	Cystadenoma Dermoid
Postmenopausal	Adenocarcinoma Brenner Fibroma	Cystadenocarcinoma

After an obstetric episode there may be rapid enlargement of the abdomen during the course of the following few months. Generally this represents pseudomucinous cystadenoma. When ovarian tumors are bilateral one must think first of malignancy, second of a dermoid cyst, and third of pseudomucinous cystadenoma. The principal way to make a diagnosis of ovarian neoplasia is by pelvic examination. Thus, it is entirely possible to remove ovarian neoplasms before they undergo malignant change, if they are recognized during a periodic annual examination. Periodic examination is much more likely to be effective in the case of ovarian neoplasia than it is in the case of cervical or endometrial malignancy.

Who should be operated on? Obviously all women with ovarian neoplasia. When should they be operated on? Upon diagnosis. It is all right to postpone the operation until next week and in a few instances to next month, but one should definitely NOT postpone operation until next year. During pregnancy, operation should be performed as in the nonpregnant woman. The dangers of interruption of pregnancy in the early months are grossly exaggerated and the breaking open of a fresh abdominal wound in late pregnancy if labor supervenes can be avoided by the use of caudal anesthesia. In fact, about the only time I would recommend removal of an ovarian cyst in conjunction with cesarean section is in the event that the ovarian tumor is incarcerated behind the pregnant uterus.

When operating on a patient with a cystic ovarian mass, the most important question is whether the mass is malignant. During a 10 year period in Dallas, 294 women with known ovarian malignancies were operated on. Only 7 of those 294 women, or 1 woman in 42, had an operation which could conceivably be called correct; that is, bilateral salpingo-oophorectomy and total hysterectomy. If this occurs in Dallas it also might occur in Milwaukee. It is absolutely necessary that the surgeon who proposes to operate on a woman with a possible ovarian neoplasm have some knowledge of the natural history of the disease and some knowledge of certain surgical principles.

The doctor must know the following characteristics of ovarian tumors:

a. The extension routes of ovarian malignancy include the other ovary, the fallopian tubes, the uterus, the parietal peritoneum, the omentum, and the liver.

b. If ascites is present the prognosis is poor, particularly if the ascites is blood tinged. The only exception to this occurs with a fibroma or a Brenner tumor.

c. Pseudomyxoma peritonaei looks and acts like hopeless malignancy, but sometimes the removal of the primary lesion will cure the metastases.

d. How does one tell whether an ovarian cyst is malignant? If it is free, if there are no adhesions, and if there is no other evidence elsewhere in the abdomen, the other ovary must be inspected and if necessary bisected in situ. On the removed cyst, look for papillations, both on the inside and on the outside, and for blood-tinged fluid in the cyst. Carry the tumor to another table to do this.

e. Dermoid cysts are frequently resectable. In view of the bilateral nature of these tumors it is wise, if possible, to conserve normal ovarian tissue.

f. How does one recognize a hydatidiform mole and lutein cystoma? There may be two very angry-looking ovarian cysts with an enlarged uterus. If there is a mole in the uterus, removal of that mole will enable the ovarian tumors to regress to normal size.

These surgical principles are of basic importance:

a. Do not tap the abdomen of any patient suspected of having an ovarian tumor or probable ascites until a diagnosis is made.

b. Make a sufficiently large incision to deliver the ovarian cyst intact, even if from symphysis to xiphoid.

c. Examine the other ovary, the uterus, the tubes, the parietal peritoneum, the omen-

tum, and the liver before beginning any surgery on the genitalia.

d. If the tumor looks benign remove it. Take it to another table to open and examine it.

e. If the tumor seems benign, peritonize and close the incision, leaving the uterus, the other tube, and the ovary. If the tumor is malignant, the operator must make a decision as to whether the patient is curable or incurable. If she is curable, both tubes, both ovaries, and the entire uterus, including the cervix, must be removed. If she is incurable it is permissible to remove the ovaries alone, in an effort to prevent the continuing formation of ascitic fluid.

f. The physician must be prepared to reenter the patient's abdomen within a week or 10 days if what he suspects is a benign lesion proves on histologic examination to be malignant. At that time the other tube and ovary and the entire uterus should be removed.

Occasionally an ovarian cyst without any adhesions becomes incarcerated in the true pelvis. In that event it is very difficult to lift out. The difficulty can be immediately overcome by insinuating a soft rubber catheter between the tumor and the parietal peritoneum of the pelvis. This will immediately break the suction.

Ovarian Malignancy

Approximately 4 per cent of all women with ovarian malignancy will be under the age of 30. Ovarian malignancy is the second or third most frequent of the genital malignancies, comprising 15 per cent of the total. No matter how hopeless the situation, it is believed that every patient deserves exploration. This is predicated upon the fact that occasionally what is seemingly a hopeless situation turns out to be amenable to cure. Recently, radioactivated collodial gold has been used postoperatively in patients with ovarian malignancy. It is too early to know whether or not this is efficacious, but already we know it is theoretically possible to deliver a cancer-killing dose to serous surfaces without making the patient ill.

Doctor Keettel at the University of Iowa is doing cul-de-sac taps on patients operated on for ovarian carcinoma, as a means of ascertaining whether or not there is recurrence. The recurrence of ovarian carcinoma is frequently in the site of the abdominal wound.

THE WISCONSIN DIABETES ASSOCIATION

Physicians interested in diabetes, as well as laymen who have diabetes or are interested in the problem, are encouraged to join the Wisconsin Diabetes Association. An affiliate of the American Diabetes Association, it has a clinical and a lay organization which work together closely. To date, the Association has sponsored camps for diabetic children, scientific meetings for physicians, educational talks for diabetics, and diabetic detection drives. The lay group of the Milwaukee chapter meets frequently under the guidance of physicians and dietitians.

Annual dues for the Wisconsin Diabetes Association are $5.00 for physicians and laymen alike. Included in the dues is a one-year subscription to *Forecast*, a national publication on diabetes. Membership in the American Diabetes Association, including a year's subscription to the journal *Diabetes*, costs $15.00.

Communities in the state are encouraged to form local chapters within the framework of the Wisconsin Diabetes Association. For further information, write the Wisconsin Diabetes Association, % Wisconsin Heart Association, 642 North Fifth Street, Milwaukee, Wisconsin.

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. D., Marquette University School of Medicine, Milwaukee

REPORT OF A CASE*

History. This 50 year old male was admitted to Wisconsin General Hospital with the chief complaint of pain in the chest. He had awakened one night with a severe, oppressive precordial pain which radiated bilaterally to the elbows and was accompanied by a sharp pain in the shoulders and neck. The pain lasted for several hours and was accompanied by a cold sweat and dyspnea. After morphine and Demerol had been given for relief, there was intermittent nausea and vomiting throughout the day. Cyanosis, edema, palpation, tightness in the chest, pain in the left shoulder, and dyspnea persisted to the time of admission. The temperature rose to 102.2 F. on the second day. Two electrocardiograms were reported as being normal. Therapy consisted of antibiotics before admission.

First Admission. On a previous hospitalization here one year earlier, the diagnosis was hypertensive cardiovascular disease and spondylolisthesis. The symptoms at that time were slight dyspnea, easy fatigability, and weakness, which began insidiously and were present for one year. Findings included a blood pressure of 185/108, no retinal hemorrhages, minimal hypertensive retinopathy, a split mitral first sound, and accentuation of the aortic second sound. With the administration of Amytal the blood pressure dropped to 122/88.

Second Admission. On the second admission there was respiratory distress and subcyanosis of the lips. The veins of the neck were distended. Moist rales were present at the right base. There was a grade II apical systolic murmur with heart sounds of poor quality. The blood pressure was 120/87, and the pulse was 100. The aortic second sound was markedly accentuated. There was tenderness at the right costal margin. There were splinter hemorrhages of the nail beds of the fingers. The first electrocardiogram showing abnormal changes was obtained. There was a polymorphonuclear leukocytosis of 20,000, which dropped to 13,000. The sedimentation rate was accelerated to 35 mm. corrected. The prothrombin time after admission varied between 18 and 9 per cent. X-ray revealed a scattered type of density in the medial lung bases and central lung fields with a suggested differential diagnosis of bronchopneumonia and pulmonary congestion secondary to heart failure.

Course. Since the patient continued to improve, oxygen was discontinued on the twenty-seventh hospital day. The next day severe occipital headaches developed, which were followed by vomiting and shock. The left pupil was dilated, and the corner of the mouth drooped to the left. There was a right-sided hyperreflexia and positive right Babinski. The patient died 11 hours later.

Clinical Discussion

Dr. G. G. Rowe: Today's conference concerns a white man, aged 50, who was in this hospital one year previously with a mild to moderate labile hypertension. He did well until just before the present and final hospitalization. Some time before this hospitalization he was stricken with a catastrophic illness characterized by severe substernal pain, which radiated to the arms, and by cardiovascular collapse. Large doses of morphine and Demerol were required to relieve the pain. We do not know how long after the onset of the acute illness he was admitted to this hospital. When admitted, he was still quite ill. We are told that two electrocardiograms, both negative, were taken before this hospitalization.

Physical examination revealed a patient with evidence of cardiac failure, pulmonary congestion, and distention of the neck veins. Erythrocyte sedimentation rate was increased, the white count was elevated with a polymorphonuclear response, and the prothrombin time was markedly depressed to 18 per cent and 9 per cent. I would like to see the chest x-ray. We are told that there

* From the University Hospitals and University of Wisconsin Medical School.

was some question whether there was bronchopneumonia or congestion of the lungs.

Dr. R. L. Baker: The lung fields were clear in an earlier film. In a recent bedside film there were patchy densities scattered throughout the right lung. The heart was somewhat enlarged. There appeared to be a calcified plaque in the aorta. There was some pulmonary congestion and there may also have been bronchopneumonia.

Doctor Rowe: The patient did fairly well for some time and was improving considerably until an occipital headache developed. The headache was followed shortly by dilatation of the left pupil and drooping of the left corner of the mouth. There were also signs of pyramidal tract involvement in the left subcortical area. There was hyperreflexia on the right side and a positive Babinski.

This is the classical story of a coronary occlusion. There are other things that it could be, but the odds are in favor of a coronary thrombosis and a very good-sized coronary thrombosis, judging from the systemic reaction that this patient experienced. I must confess that the fact that two electrocardiograms were taken before hospitalization without showing any abnormality sways me a little from this; however, we do not know the interval between the onset of pain and the time the records were taken. The patient would have shown changes within 48 hours if he had had an occlusion of any size, and this must have been a very good-sized occlusion to produce all the symptoms and signs that this patient had. It makes some difference also whether chest leads were taken in these electrocardiograms. The abnormalities of coronary occlusion will appear sooner in the chest leads than in the limb leads. If there had been an anterior wall infarct, one would expect it to show chiefly in lead I of the limb leads, whereas it should show in the majority of the precordial leads. Many times we see patients who have had electrocardiograms elsewhere who have not had chest leads, so I think that the chances are good that this patient did have a coronary thrombosis. If he had a coronary thrombosis, his chances are about 50 per cent of developing ventricular mural thrombosis. If he developed a mural thrombus overlying a fairly large area of myocardial infarction, his chances of subsequently developing embolization are reasonably good. The best bet, therefore, is that this man had a coronary occlusion of reasonable size, which caused a mural thrombus followed by embolization to the cerebral tissues, probably in the region of the lenticulostriate arteries. If that were the case, you would expect to get softening of the internal capsule with involvement of the basal nuclei. This would cause paralysis of the face on the same side and of the extremities on the opposite side.

Another possibility which should be considered is a dissecting aneurysm. The aorta in the chest film is quite tortuous, and the bulge at the lower border of the right heart is suggestive of dilatation of the aorta. If he had had a dissecting aneurysm of the aorta, involvement of the central nervous system would be highly probable. In the report of the Mayo Clinic's experience,[1] 12 out of 26 patients with dissecting aneurysm of the aorta had central nervous system disturbance. As the blood dissects away the coats of the aorta, it separates those vessels which arise from the arch, so that there may be complete occlusion of the subclavian, innominate, or carotid. If it dissects distally, there may be separation of the intercostal vessels from the aortic arch with disturbance in the spinal cord. The finding which occurs with dissection of a carotid artery would be that of a hemiplegia such as this patient apparently had, so a second choice would be dissecting aneurysm with central nervous system disturbance.

There is a third possibility which I mention chiefly because the patient was noted to have "splinter hemorrhages" beneath his nails. When one sees splinter hemorrhages, one always thinks of subacute bacterial endocarditis. I realize that any embolic process will produce them, because they are embolic occlusions of the vessels beneath the nail, but this entire disease process could be explained by subacute bacterial endocarditis with embolization of the coronary vessels and the central nervous system, followed by softening and subsequent demise. I think that this is distinctly unlikely. There is no previous history of valvular involvement, and although the patient had a grade II systolic murmur at his second illness, I think that in the presence of failure it is not significant.

I would say then that the first choice in this diagnosis is coronary thrombosis with mural thrombus in the heart, followed by embolization of the central nervous system, cerebral softening, and consequent death. A good possibility as well is that the patient's blood pressure dropped as a result of his myocardial infarction and that cerebral thrombosis rather than embolism developed.

I do not know why the prothrombin time was low. It is not stated whether the patient had had anticoagulants or not. Frequently, as you know, patients with coronary occlusion do receive anticoagulants. If he did, in all probability liver disease was not present, but the depressed prothrombin was due to anticoagulants.

Dr. R. F. Schilling: Are there any details available on when the 9 per cent prothrombin time was obtained?

Dr. O. O. Meyer: Yes, on three or four occasions the patient received anticoagulant therapy. It was started on September 22 and continued through October 11. On September 23 the prothrombin level was 9 per cent. It then rose to a maximum of 26 per cent and thereafter was lower than that. The only other time it was 9 per cent was on October 9. The patient died three days later. The last prothrombin level on October 11 was 23 per cent. At this time he was given 25 mg. of Cumopyran, as he had had none for four days.

Doctor Schilling: I suppose Doctor Rowe considered the patient to be right down to the level at which one fears hemorrhage.

Doctor Meyer: In that regard there is one other point that might be taken up. On entry to the hospital, before anticoagulant therapy, the initial prothrombin time was 66 per cent. A subsequent reading was 80 per cent. After an anticoagulant was given, the level fell within 24 hours to about 18 per cent.

Doctor Schilling: Was his response to this drug a little more rapid than you would expect?

Doctor Meyer: His dose of Tromexan was 1,200 mg. and of Cumopyran 50 mg. He had Tromexan only once, so it was being administered with caution; I would say that he was a hyperreactor. He required medication after the first six days, when he again had 25 mg. of Cumopyran. During this hospital period of about 15 days, a total of 150 mg. of Cumopyran and 1,200 mg. of Tromexan was given.

Doctor Schilling: The reason I am dwelling on the possibility of hemorrhage is that the terminal event suggests that intraventricular hemorrhage occurred. I would like somebody more versed in neurology than I am to comment on it.

Doctor Meyer: You have some pertinent notes in that regard, Doctor Brown?

Dr. J. F. Brown: When I first saw the patient at 6:30 p. m., he was complaining of severe pain in the neck and occipital region. At that time there were no objective changes. There was a certain amount of apprehension. He was sedated, and at 11:00 p. m. the reflexes were slightly more active on the right with a positive Babinski, and the left pupil became larger than the right. Both pupils reacted to light. He was somewhat irrational at this time. There was moderate stiffness of the neck, and at that time 100 mg. of vitamin K_1 was given. A Wangensteen suction was started because of continued vomiting. At 12:15 a. m. he appeared improved except that he still complained of a severe occipital headache.

Doctor Rowe: What happened to his blood pressure and his pulse?

Doctor Brown: The blood pressure at 11:00 p. m. was 118/96, pulse was 104, and respiration was 24. By 3:00 a. m. he reacted only to painful stimuli. His breathing was snorting in character; the blood pressure was 138/96; the pupils were miotic and did not react to light. My impression at 11:00 p. m. was that he had had a cerebrovascular hemorrhage.

Question: Was a lumbar puncture done?

Doctor Brown: No, sir.

Doctor Rowe: With this information one would feel that hemorrhage is a lot more likely than a thrombus or an embolism.

Doctor Schilling: How about the significance of the time interval between the onset of the accident and the time of death in deciding between embolism and hemorrhage, and how about the presence of severe occipital headache on the basis of embolism? I think a person dying within 11 hours after the onset of a severe occipital headache would be more likely to have a hemorrhage than embolism.

Dr. Joseph J. Lalich: Yes. In a study made by Doctor Harman, it was found that with cerebral thrombosis or embolization the symptoms appear more slowly and the pa-

tient lives much longer than with cerebral hemorrhage.

Dr. John Rankin: I do not think that one can in any single case ever determine the exact nature of the lesion at the onset. In the last four or five years I have reviewed about 600 cases of cerebrovascular accident in an attempt to arrive at a diagnosis. Patients who suffer from hemorrhage have a much more severe and sudden onset and usually die within one to five days, whereas with cerebral thrombosis most of them recover. They have many more lesions, but the signs and symptoms present are more an indication of the extent of the lesion than they are of the nature of the lesion. In this man I would like to suggest the possibility of cerebral hemorrhage with the main eruption into the subarachnoid space. He seems to have retained consciousness for a considerable time in spite of an early marked increase in intracranial pressure. It is unlikely that with a large intracerebral hemorrhage which remained intracerebral he would have retained consciousness so long. Likewise, in the case of an embolism which is usually maximal at onset, recovery is frequently continuous from the beginning unless either another embolus or hemorrhage occurs in the area itself.

Necropsy Findings

(University Hospitals 52:261)

Dr. H. A. Hartmann: The heart was hypertrophic (450 Gm.) with an infarct involving the lateral wall of the left ventricle. The necrotic area measured 7 by 3 cm. and was well demarcated from the surrounding myocardium. There was no evidence of intracardiac mural thrombosis. On microscopic examination no nuclei were seen in the myocardial fibers, which were extensively necrotic. Fibroblasts and capillaries were growing in from the side, indicating early organization.

The coronary arteries showed extensive sclerosis. There was an old thrombus occluding the circumflex branch of the left coronary artery about 2 cm. from the ostium. There was also an extensive sclerosis in the aorta which was most marked in the abdominal portion.

The only other findings of significance in the general examination were an acute pulmonary edema, a chronic passive congestion of the liver, and a diverticulum of the urinary bladder.

Opening the skull revealed a subdural and subarachnoid hemorrhage of about 200 cc. The subarachnoid hemorrhage was particularly noted over the occipital lobes of the cerebrum, the cerebellum, the pons, and the medulla. When the brain was sectioned, the widely dilated ventricles were found to be filled with partly clotted blood. The vessels at the base of the brain showed severe sclerosis. The media of the cortical arterioles was moderately calcified. There was also perivascular demyelinization with some evidence of previous small hemorrhages. Small areas of glial proliferation were also noted.

In summary, the autopsy confirms the clinical diagnosis of left ventricular myocardial infarct. We were not able to establish any point of hemorrhage such as from an aneurysm. There is no doubt that the cerebral arteriosclerosis represented a focus of lessened resistance; however, with the drop in blood pressure following the myocardial infarct (from 185/108 to 120/78), one hesitaes to explain the hemorrhage on the basis of sclerosis alone. We favor a generalized bleeding tendency, since this patient was treated with anticoagulants. It has been shown that a prothrombin level below 20 per cent may be dangerous. One possible explanation lies in the modern theories of coagulation as formulated by Quick, Seegers, or Owren. We must focus our attention on the newly discovered factors participating in the formation of thromboplastin. Owren[2] names one of these factors *convertin.* He has observed during Dicumarol therapy that convertin occasionally may almost completely disappear while prothrombin is still in the therapeutic range (20 per cent).

Finally, I should like to mention the experimental work done by Lalich and Copley,[3] suggesting that these factors are involved in hemostasis.

Doctor Lalich: There are several things that might be said about this case. One thing, of course, is that the coagulation theories grow more complex each year. Doctor Copley and I did bleeding, coagulation, and prothrombin times in mice. By prothrombin studies alone we were unable to anticipate when bleeding would or would not occur. Of course, at that time we had no explanation for this observation. According to Owren, apparently the thromboplastin ac-

tivator is an equally important factor in determining whether or not an animal or possibly a human being will or will not bleed. Another thing of some importance, because it focuses our attention on therapy, is the presence of arteriosclerosis. The coronary thrombosis was complicated by an extensive arteriosclerotic process with a rather marked diminution in the size of the lumen. Recently, in a series of young soldiers, it was observed that the arteriosclerotic reduction of the lumen caused myocardial infarction in about 35 to 40 per cent of the cases. I'd like to ask Doctor Meyer a question. When there is occlusion of the lumen by an arteriosclerotic plaque, how much good will Dicumarin or any anticoagulant do?

Doctor Meyer: I can answer your question in two words, but I want to make a few comments. We have believed for a long time (and the statistics show it) that anticoagulant therapy is not likely to lessen the incidence of subsequent coronary occlusion. As a matter of fact, in Wright's series of cases, it did not lower it less than 10 per cent. That's what you would expect, if you grant that most coronary occlusion is dependent on the status of the coronary arteries, not on the status of the blood. But the overall mortality is lowered approximately 30 per cent or more, because anticoagulants eliminate complications to a considerable extent, notably cerebral and pulmonary emboli, by lessening the incidence of intra-auricular clot or by lessening the incidence of mural thrombus. Now there is quite a bit being written about when you should and should not use anticoagulants for coronary occlusion. We have never felt that it was indicated in every patient but have believed that it was usually proper therapy, and we have felt that way in part because we believe the risk of anticoagulant therapy is slight. When we have observed serious episodes from anticoagulant therapy, it has been mainly the fault of the administrator and not of the drug. We have taught from the very beginning that the proper level of prothrombin is 20 to 40 per cent, and there is some experimental data of Moss, Kirby, and Shafer, working in Ravdin's laboratory, to show that levels below 40 per cent are not additionally helpful in the lessening of thrombus formation in an artery in the dog. Also the evidence is available both from Doctor Owren's work, which Doctor Hartmann has quoted, and from Doctor Quick's work in Milwaukee that you have little likelihood of bleeding from anticoagulant therapy until the prothrombin level is below 20 to 25 per cent, and that is pretty sound clinical experience in thousands of patients. There are hyperreactors, it is true, so one must be cautious.

Wright and his group, as well as others, have made it pretty much routine in the management of coronary thrombosis to treat to the point where the prothrombin time is from 10 to 30 per cent. Since we have had no reason to think that it is advantageous to go below 20 per cent, we recommend 20 to 40 per cent. However, we advocate a level closer to 20 than to 40 per cent.

It is fundamental, of course, that one does not bleed until blood escapes from a blood vessel, and vascular factors do play a role when bleeding occurs. I am inclined to agree completely that anticoagulant therapy will not lessen the likelihood of coronary thrombosis in many instances but it will prevent complications.

Just one other point apropos of this patient. He came in with a prothrombin time of 66 per cent, which rose to 80 per cent. Dr. Fred Pohle used to emphasize the point that when prothrombin times are done on whole plasma, not using dilute plasma, saying 100 per cent means 100 per cent or anything above that. When you record anything less than 100 per cent, 90 or 80 per cent, for example, it means that there is no reserve, there is no excess beyond that short 12-second time of 100 per cent. Therefore, one can anticipate that the prothrombin will fall very sharply with any amount of anticoagulant. The physicians did use caution in this patient, they did employ smaller doses than we are likely to use, but I can assure you that if you treat a patient who has less than a 100 per cent prothrombin, you must be extremely thorough in attention to detail because he is the one that is likely to get into trouble. This patient was maintained at low levels. The day before he died he had 23 per cent, which is reasonable, but much of the time he was below 20 per cent, a level where we have thought you are likely to get into trouble. Quick has thought so, although Wright and many others believe that this is a safe range.

Doctor Lalich: We have asked Doctor Deutsch to say a word or two about coagulation.

Dr. H. F. Deutsch: I would just like to ask Doctor Meyer one question. Do you feel that there is such a thing as hyperprothrombinemia? You stressed starting at 100 per cent. Do you think that some patients who are essentially normal go up to 150 per cent and that there is such a thing as hyperprothrombinemia?

Doctor Meyer: There is some evidence that that is so. When you dilute plasma 50 per cent, you can get a prothrombin time shorter than you would normally get, suggesting that there is an excess.

Doctor Deutsch: But could it be an excess of some of these other factors?

Doctor Meyer: Oh, yes, that's true. I think the point that Doctor Lalich has brought out about the other factors is pertinent. No one questions that anticoagulants of the coumarin type modify other factors. I don't know a great deal about them, I'll admit, but from the clinical experience, the determination of the prothrombin time itself is reasonably good (reasonably satisfactory as a guide), and I do not think myself, as of now, that it is necessary to determine other factors in ordinary clinical practice. I'm sure that for some experimental purposes, however, you must do more.

Doctor Deutsch: I asked about hyperprothrombinemia because in several hundred rats we have never found anything like a hyperprothrombinemia, although I think that Link claims that such a consideration obtains. We did find in several cases when a low vitamin K diet was fed that the animals showed a complete lack of fibrinogen. By the ordinary prothrombin time you would assume they had no excess prothrombin. When you added fibrinogen to their plasma, they had a hyperprothrombinemia, but in several hundred normal animals we never could demonstrate an increased content of prothrombin. The coagulation schemes are getting quite fascinating in terms of complexity, but there is a lot more that is going to come out in that area. This Owren's scheme that was put on the board said nothing about heparin or antithrombins or heparin cofactor. Now you can get the same bleeding tendency if you have a deficiency of heparin production, a deficiency of heparin complement, or deficiencies of other antithrombins. So the situation is horribly complex, and I think that before there will be any real understanding of it these substances will have to be purified so one can really assay one thing and not be assaying a summation of 10 factors. I always tell the first year class that the only thing that has been purified and that one can measure accurately in the blood clotting cycle today is calcium.

REFERENCES

1. Moersch, F. P., and Sayre, G. P.: Neurologic manifestations associated with dissecting aneurysm of aorta, J.A.M.A. 144:1141–1148 (Dec. 2) 1950.
2. Owren, P. A.: Prothrombin and accessory factors, Am. J. Med. 14:201–215 (Feb.) 1952.
3. Lalich, M. H., and Copley, A. L.: Bleeding time in mice following oral administration of 3,3'-methylene-bis-(4-hydroxycoumarin), Surgery, 13:316–321 (Feb.) 1943.

SUMMER CAMP SCHEDULED FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fifth season under the auspices of the Chicago Diabetes Association, Inc., from July 21, 1953, to August 10, 1953, at Holiday Home, Lake Geneva, Wis.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by the Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee for $150.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

Service Unit, Chicago Diabetes Association
110 South Dearborn Street
Chicago 3, Illinois

Limited capacity requires prompt application.

THE MEDICAL FORUM

GOVERNOR SIGNS REVISED MEDICAL PRACTICE ACT

Legislature Okays $1,500 for Grievance Committee

Madison, June 29.—The state medical grievance committee will be allotted $1,500 annually as a result of a law passed by the legislature and signed by the Governor. The bill was introduced by the Legislative Council, at the request of the state board of health.

The committee consists of representatives of the board of medical examiners, the attorney general and the state health officer. Its responsibility is to investigate, hold hearings, and to take such action as may be indicated relative to practices of physicians that are inimical to the public health.

SEN. ARTHUR LENROOT

5 Chiropractic Bills Defeated; Lose Bid to be Called "Doctor"

Madison, June 29.—Chiropractors came out with a strong, but unsuccessful, legislative program during the 1953 session. Every chiropractic bill inimical to public health was defeated by the legislature and thus remains a dead issue so far as the current session is concerned. These bills were vigorously opposed by the State Medical Society.

Sought Title "D. C."

One of the most bitterly fought chiropractic bills was a proposal to give chiropractors the title "D.C." and thus, indirectly the title "doctor."

This measure passed the Assembly but was defeated in the Senate. No accredited college in the United States recognizes the training or degree in chiropractic.

Among other chiropractic proposals which were defeated in the legislature were:

1. Two bills which would have given employees the right to choose a "specialist" in workmen's compensation cases. "Specialist" was not defined but it presumably included chiropractors.
2. A bill to give a workman his choice of chiropractor under the compensation act in event of a back injury.
3. A proposal that the chiropractic board could define "unprofessional conduct" among chiropractors. The measure was so broad that if, for example, the board determined that it was unprofessional conduct not to take routine urinalyses, blood pressures, electrocardiograms, and the like, the chiropractors could extend their field of practice into areas in which they are neither trained nor otherwise qualified.
4. A proposal that chiropractors be examined in such subjects as general diagnosis, x-ray, neurology, and hygiene and sanitation. If passed, chiropractors would have claimed rights and privileges now denied—such as being health officers, using x-ray for treatment, or representing themselves as neurological specialists.

Medical Society's Program Approved

Madison, June 29.—The Governor signed three bills proposed by the State Medical Society for the revision of the medical practice act and the modernization of the state board of medical examiners.

All three bills were introduced by Senator Arthur Lenroot, Superior. The bills revise the medical practice act in all general principles and in virtually all details as originally proposed by the society.

Under one of the bills, Madison is established as the site of permanent offices of the board. The board will be permitted to select its own secretary and administrative officer. The society had originally proposed that the secretary be the state health officer as a means of implementing the establishment of Madison offices. This suggestion was later dropped to assure the achievement of the major objective —capitol headquarters.

As a result of the new law, the board of medical examiners will meet quarterly as a means of assuring more speedy licensure of physicians. The new board will consist of eight members, seven M.D.s and one osteopath.

The medical society will be permitted to submit nominees for the M.D. members, although the Governor need not select them from the list. An obsolete requirement that the board members include eclectics, allopaths, and homeopaths was eliminated.

The statutes relating to licensure were modernized with the result that the public has greater protection from quackery. Among the new provisions:

1. The court and statutory definition of the term "treat the sick" has been made uniform, thus eliminating a loophole for quackery. Christian Science is established as the only recognized form of treatment of the sick by mental and

(Continued on page 402)

GOVERNOR SIGNS . . .

(Continued from page 401)

spiritual means. Previously, quacks claimed exemption from the act on the basis that they were using mental and spiritual forms of care.

2. Hereafter, the board of medical examiners must conduct an investigation and hold a public hearing before approving or recognizing any osteopathic or medical schools as providing training equivalent to that provided by the University of Wisconsin Medical School. Applicants for reciprocity will have the right to public hearing and the board is required to investigate whether the requirements for their existing license are equivalent to those of Wisconsin.
3. Reciprocity is provided with all branches of the armed services. At the present time, Air Force and Public Health Service veterans are excluded from reciprocity. Application must be made within one year of discharge.
4. Immoral or unprofessional conduct is defined to include "engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public." A court action would be necessary to obtain revocation of license under this section. At the same time, the new law permits the board to accept a voluntary surrender of license.
5. An obsolete requirement that physicians record their licenses with the county clerk has been eliminated.

Bill 161, S. was fought bitterly by the chiropractors, but passed both Houses exactly as introduced by the society. It deals with the basic science law and provides that:

1. The basic sciences are now pathology, physiology, anatomy, and diagnosis. This provision was modified so as to define diagnosis as physical diagnosis. This clarifies the law, and eliminates the claims of some cultists that being examined in "diagnosis" they are privileged to use all modalities of diagnosis.
2. The Wisconsin basic science examiners may accept the basic science examination of the National Board of Medical Examiners in lieu of its own examination.
3. Applicants are to be examined in all four basic sciences. The present law permits those who claim they will confine their practice to "one organ" to limit their examination to that organ. Chiros have claimed the spine is an organ and about one third of the chiropractors are examined only in the spine at the present time. Hereafter, this is eliminated.

The board of medical examiners will hold its first meeting under the new medical practice act on July 14-16.

VA Budget Letters Swamp Rep. Laird

Washington, D. C., June 25.—Rep. Melvin R. Laird, Marshfield, reports that his office is being flooded with letters demanding increases in the budget of the Veterans Administration for the fiscal year 1954.

In his June newsletter, Rep. Laird reports that information is being circulated throughout the nation that the VA does not have enough funds at the present time to take care of veterans in need of hospital care.

Has Sufficient Funds

"This information is not based upon fact," reports Rep. Laird. "The VA presently has sufficient funds. As a matter of fact, the VA will lapse at the close of the fiscal year 1953 in excess of 8 million dollars in its hospital account."

Rep. Laird pointed out the necessity for a "top-flight administrator" to head the department. According to Rep. Laird the research task force of the House Appropriations Committee suggested an appropriation of $513,200,000 for the fiscal year 1954 for VA hospital care. President Eisenhower asked for $523,000,000.

The research group pointed out that its suggestion could be reduced by 50 million dollars if financial responsibility requirements are enforced on the treatment of nonservice connected cases in VA hospitals.

REP. MELVIN R. LAIRD

NATUROPATH BILLS ARE DEFEATED

Madison, June 29.—The naturopaths were back again with two proposals and much hullaballoo for legislative recognition. Both of their proposals were defeated.

One bill was an attempt to permit chiropractors to practice naturopathy, if the chiropractor presented a certificate from a "legally established naturopathic association." His proficiency was to be determined by his membership in a private naturopathic association of unknown standards.

The other bill would have included naturopaths in the medical practice act and on the board of medical examiners. This device would have completely integrated naturopathy with medicine. Under this proposal naturopaths would have been given the title "N.D."

Legislative hearings on these bills were accompanied by personal testimonials from dozens of residents from Milwaukee and Sheboygan Counties.

Abolish Statutes Certifying Midwives

Madison, June 29.—Midwives will no longer be certified in Wisconsin as a result of a law passed at the suggestion of the state medical society.

The law licensing midwives was abolished, but a "grandfather's clause" permits the continued practice of those now certified.

FOREIGN STUDENTS MAY GET TEMPORARY EDUCATIONAL CERTIFICATES IN STATE

Madison, June 29.—Foreign educated medical students may now obtain temporary educational certificates to take postgraduate work in approved teaching hospitals in Wisconsin.

Assemblyman Mark Catlin, Appleton, introduced the bill at the request of the state medical society. The Governor has signed it into law.

The new law allows persons on temporary visas (who are ineligible for citizenship and thus unable to be licensed) to continue their education in hospitals which the board of medical examiners recognizes as "teaching" institutions.

The board of medical examiners has not yet set up the mechanism for the approval of the teaching institutions or the granting of the certificates. It is expected to develop this mechanism at an early date.

Number Limited

Up to 25 certificates may be accepted in any one year, with a maximum of 75 certificates out at any one time. Certificate holders could prescribe drugs other than narcotics, and sign any certificates, reports or other papers for the use of public authorities which are required of one licensed to practice medicine and surgery. The holder of a certificate may, under the direction of a person licensed to practice medicine and surgery in Wisconsin, perform services requisite to the training authorized under the law.

The holder of an educational certificate must confine his training and practice within the hospital in which he is taking his education. Neither he nor the hospital may receive any fees or other income for his services from any patient treated by him during the course of training.

At the present time, an increasing number of Fulbright fellows and others who hold degrees from medical or osteopathic schools are seeking postgraduate training in the United States so as to take back to their countries the benefits of such training. These men do not plan to remain here after their training has been completed. Further, they cannot become citizens while they remain the guests of the United States government.

ASSEMBLYMAN MARK CATLIN

Qualified hospitals in Wisconsin, as elsewhere, are willing to provide such advanced health training. The new law recognizes the responsibility of Wisconsin, with its two distinguished medical schools, to help make such training possible to holders of degrees from other lands.

MDs Get Out Leaflets to Accompany Plaques

Evansville, Ind., June 20.—Evansville, Indiana physicians were quick to capitalize on the public relations opportunity offered by the posting of the new AMA plaques. The plaques invite patients to discuss fees with their doctors.

When the Vanderburgh County Medical Society made these plaques available to local doctors, the doctors got out a leaflet entitled "To All My Patients" which reproduced the plaque's message on its cover. It explains that physicians fees are based not only on the time and effort spent with the patient but also on the time and effort he spent in acquiring the skill and judgment he uses in serving the patient.

The leaflet goes on to explain that many arrangements can be made for easy payment of medical bills and emphasizes the fact that doctors have high operating expenses and must pay heavy taxes too. Patients are also urged to call on their medical society for information about medical services and facilities.

U.S. Government Writes 5 Billions in Insurance

Chicago, June 6.—The Federal government is in the insurance business to the tune of five billion dollars a year, according to an Insurance Economics Survey.

The survey lists eleven major insurance operations which include life insurance for men in the armed forces and veterans; marine and aviation war risk insurance; old age and survivors insurance; railroad employes' retirement system; civil service employes' retirement system; unemployment compensation; federal employes' compensation; crop insurance; insurance of commodities under Commodity Credit Corporation loans; guarantees of bank and other depositories and guarantees of mortgage loans.

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

PRESIDENT SIGNS NEW "DOCTOR DRAFT" LAW

Provisions Became Effective June 29

Madison, June 30.—The Wisconsin Advisory Committee to Selective Service has received a copy of the new doctor draft law as signed by the President.

The President's signature extends the effective date of the doctor draft law until July 1, 1955. It retains the maximum age for registration at 50 and liability for induction at age 51.

Priorities Continued

The four priorities established by the previous law were continued in effect with the following amendments:

(a) All service performed since September 16, 1940 as an officer or as an enlisted man, with certain exceptions which will be outlined later, will be credited as service. At the present time doctors in priorities 1 and 2 only receive credit for service performed "subsequent" to deferment or participation in a Navy V-12 or Army Specialized Training Program during World War II;

(b) The length of service required to qualify for priority 4 for doctors who were deferred or educated at government expense during World War II is reduced from 21 to 17 months. As a result of this provision a substantial number of doctors will be reclassified from priority 2 to priority 4;

New Periods of Service

(c) Establish the following new periods of service for men recalled to active duty or inducted pursuant to the "Doctor Draft Law":

Previous Service	New Period of Duty
9 months or less	24 months
9 to 12 months	21 months
12 to 15 months	18 months
15 to 21 months	15 months

(d) Removes the liability for induction or recall to active duty, except in time of war or national emergency hereafter declared by Congress, for those men in priority 4 who have had 21 months or more of service since September 16, 1940.

"Active duty" and "active service" are defined to include:

(a) Full-time duty in the active service of the United States since September 16, 1940 in the Army, Navy, Air Force, Marine Corps, Coast Guard or United States Public Health Service, including reserve components;

(b) Time spent during World War II in work of national importance by conscientious objectors;

(c) Service performed before September 2, 1945 in the Armed Forces of countries which were allies of the United States during World War II; and

(d) Service performed as a physician or dentist by United States citizens employed by the Panama Canal Health Department between September 16, 1940 and September 2, 1945.

Training Time Excluded

The bill excludes from consideration as "active duty" periods spent in a Navy V-12 or Army Specialized Training Program; in a military internship, residency or senior student program; in military service for the sole purpose of undergoing a physical examination or while engaged in active duty for training entered into after June 29, 1953.

It authorizes the appointment of medical officers in grades commensurate with their professional education, experience or ability. This section is intended to provide for uniform treatment with respect to the ranks of all doctors called to active duty irrespective of whether they had previous military service;

It continues until July 1, 1955 the authority to provide the "Special Pay" of $100 per month for doctors in the Armed Forces. This section also extends the class of persons eligible for such pay to include veterinarians;

Non-Citizens as Officers

In addition, the new law:

(a) Authorizes the commissioning of non-citizens of the United States as officers in the Armed Forces;

(b) Terminates automatically, upon completion of 12 months or more of service subsequent to September 9, 1950, the reserve commissions of all physicians taken into service by operation of the "Doctor Draft Law". Upon completion of this same service medical reservists recalled to active duty will be given an opportunity to resign their commission. Such persons, whether registrants or reservists, shall not be liable thereafter for recall or reinduction except in time of war or national emergency hereafter declared by the Congress;

(c) Reenacts the present provisions of law which permit the deferment of those individuals who are essential to the national health, safety and interest;

Can Recommend Deferment

(d) Authorizes the national, state and local medical advisory committees to the Selective Service System, in addition to their present authority, to make recommendations with reference to the deferment of (a) registrants engaged in residency training, (b) those serving on faculties of medical and certain other schools and (c) those engaged in essential laboratory and clinical research;

(e) Extends until July 1, 1955, the authority of the President to recall medical reservists to active duty involuntarily;

(f) Is to be retroactive in effect. Those men already in uniform who would have benefited from the new changes in the law will, upon filing an application, be eligible for release from service as soon as possible and in no event later than 90 days after the effective date of the Act (June 29, 1953).

(Continued on page 405)

New Plan to Be Used in Calling Doctors Without Service

Although it is not a part of the draft law, the Armed Forces appear to have agreed upon a procedure of taking Priority III physicians equally from the lower and upper age brackets after the calling of physicians who have just completed internships.

In other words, it appears that physicians may be taken equally from the age groups above and below 30.

"The object is to prevent those in Priority III from getting beyond the age limit before they are called," according to Senator Hunt (D. Wyo.). "The military is going to watch that rather closely," the A.M.A. reports Senator Hunt as saying.

Kohler Names 5 New Members to Board of Medical Examiners

Madison, June 20.—Five new members of the Wisconsin State Board of Medical Examiners were named by Governor Walter J. Kohler during the month of June.

In his announcement, Governor Kohler named the following appointees:

Drs. J. A. Schindler, Monroe, and Millard Tufts, Milwaukee, replace Drs. A. F. Rufflo, Kenosha, and E. W. Miller, Milwaukee, whose terms ended July 1.

Drs. J. W. McRoberts, Sheboygan, T. W. Tormey, Jr., Madison, and C. A. Olson, Baldwin, replace Drs. J. W. Smith, Milwaukee, and H. H. Christofferson, Colby, who resigned their positions, and to fill the position left vacant in 1951 by the death of Dr. C. A. Dawson, River Falls.

E. C. Murphy, D.O., was reappointed for another four-year term.

Other members of the Board are Drs. A. G. Koehler, Oshkosh, and J. W. Prentice, Ashland.

GOVERNOR KOHLER

DOCTOR DRAFT . . .

(Continued from page 404)

In considering the over-all effect of the new law it should be noted that the major changes involve greater recognition of prior military service. The result is that a particular registrant, by being able to take advantage of the various new provisions, may either (a) become exempt from liability for service, (b) be placed in a priority less vulnerable to immediate call, (c) be subject to a reduced term of service, or (d) effect a severance of military status within 90 days upon application or after the completion of his period of service by being either discharged or permitted to resign.

These amendments will remove many of the inequities which now exist. Many of the recommendations made by the American Medical Association in its testimony before the Armed Services Committees of the House of Representatives and the Senate were accepted.

Emergency Call Service Starts in Fond du Lac

Fond du Lac, May 16.—Fond du Lac physicians who serve on the staff of St. Agnes hospital have arranged a round-the-clock call service to handle emergency cases.

According to Dr. H. J. Kief, chairman of the committee in charge, each doctor on the staff has signed up to maintain a schedule that will put him on 24-hour "call" on a rotating basis. This list of doctors is kept at the hospital, and the doctor on duty is called when it is his day if an unattached case comes up.

If the service is called because the regular family doctor is not available, the hospital makes every effort to locate this physician. If he is not available, the call is then turned over to the "volunteer" doctor.

BILL LEGALIZES ORAL PRESCRIPTION

Society Successful in Fight Against "Dangerous Drug" Amendment

Madison, June 29.—A pharmacy bill legalizing oral prescriptions and establishing certain consistencies with federal drug laws became a law as a result of the 1953 session, but only after a state medical society amendment was adopted.

The medical society amendment eliminated the addition of thousands of drugs to the list of drugs which are now known as "dangerous" and therefore require a prescription.

If the Wisconsin Pharmaceutical Association is correct in its present opinion that physicians' employees may not assist them in the dispensing process, the addition of those drugs would have virtually prohibited all dispensing through physicians' offices, no matter how essential it might be to patient, health, or convenience, medical society officials stated.

Under the new law, physicians may telephone prescriptions to the pharmacists who must later reduce the telephone prescription to writing.

Marriage of Epileptics Legalized in State

Madison, June 29.—The marriage of epileptics is permitted in the future as a result of passage of the medical society's bill on this problem. Previously, marriages between epileptics were null and void in Wisconsin.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

BLUE CROSS PAYS $50,000,000 TO HOSPITALS; FORD TELLS DOCTORS NOT TO BE SO CONSERVATIVE

Milwaukee, June 24.—More and more Americans seem to be demanding an adequate health financing system that includes preventive and diagnostic as well as curative care, declared Benson Ford, vice-president of the Ford Motor Company, at a dinner marking the payment of the first 50 million dollars to Blue Cross subscribers in Wisconsin.

More than 350 hospital executives and trustees, physicians, Blue Cross–Blue Shield employees and others interested in the field of health attended the meeting. Blue Cross started operations in Wisconsin in 1940 and now has more than 800,000 subscribers. It is currently making payments for hospital care at the rate of $12,000,000 per year.

Dr. J. C. Griffith, Milwaukee, president of the State Medical Society, and Dr. R. S. Irwin, president of The Medical Society of Milwaukee County, expressed praise for the accomplishments of Blue Cross.

Ford said he was "not in the least worried about the so-called threat of 'socialized medicine'." He said demands for better medical care were part of the American tradition. "We have a great opportunity," he said, "to develop a system of private medical care so attractive as to eliminate most of whatever desire may exist for greater governmental control of medicine."

He warned the medical profession, however, that they should not hamper progress by being too conservative.

In addition to giving encouragement to group medical practice, he said, "only progressive thinking and concrete action for the establishment of an adequate health care system can guarantee that private medicine will stay in private hands."

"I believe that the management of Blue Cross has been outstandingly progressive . . . . but there are limits to what it can do without understanding and cooperation from the other parts of the medical quadrangle—the patient, the doctor, and the hospital."

Headliners for the celebration marking the payment of $50,000,000 for hospital care of Wisconsin Blue Cross members were (left to right) Anthony von Wening, Milwaukee; B. E. Miller, Madison, president of the Wisconsin Blue Cross Plan; Benson Ford, vice-president of the Ford Motor Company, and president of Henry Ford Hospital, Detroit; George Bugbee, Chicago, executive director of the American Hospital Association.

AMA Seeks Deduction for Doctors Taking Postgraduate Courses

Washington, D.C., June 26.—The American Medical Association has appealed to Congress to authorize physicians to deduct postgraduate educational expense for income tax purposes.

Dr. Walter B. Martin, Norfolk, Va., president-elect of the American Medical Association, told the House of Representatives Committee on Ways and Means that recent Bureau of Internal Revenue and court decisions have not made it clear that professional men are entitled to deduct expenses incurred in attending refresher courses.

The United States Court of Appeals recently ruled that expenses incurred by an attorney in taking postgraduate courses were deductible for income tax purposes. The A.M.A. pointed out that this decision may not apply to physicians, and therefore legislative action is needed.

Two-Fifths of Income of Average Physician Paid Out for Expenses

Rutherford, N. J., June 18.—The average physician in private practice spent $9,508—two-fifths of his gross income—on operating expenses in 1951.

This is revealed in the January issue of Medical Economics, national business magazine for physicians. The magazine is publishing the results of a nationwide survey of medical practice, based on a questionnaire sent to each of its 134,000 MD-readers.

According to the survey, the average doctor's professional expenses rose 24 per cent from 1947 to 1951.

Medical Economics found that doctors in small towns generally spend a higher percentage of their gross income on expenses than medical men in large metropolitan centers. Operating costs also tend to be proportionately higher among physicians with low incomes than among those in the upper brackets.

Okay Licenses For Physical Therapists

Masseurs will Continue under Grandfather's Clause

Madison, June 29.—Physical therapists achieved much deserved legislative recognition during the 1953 session. The Governor signed Bill 238, A. which licenses physical therapists only under the direction of a licensed physician. It abolishes the future registration of additional masseurs and hydrotherapists.

The bill was introduced by Assemblyman Nicholas Lesselyoung, Fond du Lac, at the request of the State Medical Society. An identical measure introduced by Senator Melvin J. Olson, South Wayne, was under discussion by the legislature, but required no action because of the passage of the Assembly bill.

Masseurs now practicing may continue under a "grandfather's clause" agreed upon by the masseurs, state medical society, and physical therapists.

Masseurs may continue to practice massage, and present limitations are continued to the effect that they may not treat the sick except upon the prescription and direct supervision of a physician.

ASSEMBLYMAN LESSELYOUNG

The medical society came under heavy fire throughout the session by masseurs and pseudo-physiotherapists who apparently feared the new law would expose their present law violations, lack of training in the use of highly technical equipment, and inability to meet the qualifications of bona fide physical therapists.

The Veterans Administration, National Polio Foundation, and Wisconsin Association for the Disabled were among other supporters of the bill.

Certify Hospitals Under New Law

Madison, June 29.—Certification of hospitals in Wisconsin was approved by the legislature and the Governor in a move designed to make federal old-age assistance available to eligible persons residing in hospitals.

The necessity for this legislation arose out of the Social Security Act which specifies that federal aid for the payment of old-age assistance, aid to the blind, and aid to dependent persons, is available to persons confined in hospitals only when those hospitals meet certain standards.

Under the law, a special advisory committee will assist the state board of health in the development and enforcement of standards for approval of hospitals. Hospitals meeting these standards will be certified by the state and that certification cannot be withdrawn without a specific reason.

Hospitals will be given a "reasonable time" in which to comply with such standards.

New Wisconsin Hospitals Cost Over $29,000,000

Washington, D.C., June 22—A total of 23 hospitals have been built in Wisconsin under the Hill-Burton Construction Act, according to Frank E. Wilson, M.D., director of the Washington office of the American Medical Association.

Reporting on a survey by the Federal Security Administration, Doctor Wilson stated that the 23 hospitals were built at a total cost of $15,715,000, including federal contributions totaling $6,132,000. The hospitals supply 990 additional beds.

In addition, Doctor Wilson reported that 12 hospitals are under construction in Wisconsin at a total cost of $12,853,000, including federal contributions of $4,300,000. The 12 projects will supply 699 additional beds.

Approval has already been given to three more hospital projects at a total cost of $1,115,000, to supply 81 additional beds.

MEDICAL SCHOOL ADDITION VETOED

Kohler to Study School's Problems; Still Hope for Passage

Madison, July 3.—Gov. Walter Kohler vetoed a $2,800,000 appropriation for an addition to the University of Wisconsin Medical School. The measure had passed both houses and had the support of the state medical society. The bill passed the Senate 24–3 and the Assembly 82–0.

The measure was introduced by Senators R. P. Robinson, Beloit; J. E. Leverich, Sparta; Bernhard Gettelman, Milwaukee; M. L. Olson, South Wayne; C. E. Dempsey, Hartland; E. F. LaFond, Two Rivers and A. J. Busby, Milwaukee.

Move is Surprise

The surprise move was explained by Gov. Kohler as an effort to keep the state out of the red during the coming fiscal year. He said he plans to study the entire "situation" during the summer.

In vetoing the bill, Gov. Kohler proposed an alternative. He suggested that the Wisconsin High School close to the medical school on the University campus be taken over and be remodeled for the use of medical school students. He said the remodeling could be done at a cost of $1,000,000.

In his veto message, Gov. Kohler said he was "in full accord with the stated purpose of this appropriation, which is to increase the number of graduates from the medical school."

"More Doctors Needed"

"More doctors are needed, and facilities should be provided for their training," he said. At hearings before the Legislature recessed, the medical society and medical faculty members said the new building would permit the school to increase its yearly graduating class from 80 to at least 110 doctors.

The bill came out of an investigation by a Legislative Council subcommittee on public welfare headed by Assemblyman Robert E. Lynch, Green Bay. The committee reported that it had "personally investigated this 'bottleneck' and was astonished by the deplorable inadequacy of facilities for the critical pre-clinical years of training.

DR. DEVITT HEADS NURSING SURVEY

Madison, June 28.—Dr. J. S. Devitt, Milwaukee, has been named chairman of the committee on nursing education of the Council on Medical Service of the State Medical Society.

Other members of the committee appointed by Dr. D. E. Dorchester, chairman of the Council are:

Drs. J. S. Wishart, Eau Claire; G. S. Custer, Marshfield; J. D. Schroeder, Janesville; W. J. Tucker, Ashland; A. H. Heidner, West Bend; R. C. Parkin, Madison; G. B. Merline, DePere, and Mrs. V. S. Falk, Edgerton.

Mis Adele Stahl, director of the State Department of Nursing, will participate in all meetings.

The committee will hold a preliminary meeting in July or August to lay plans for its study of nursing education. One of the major questions to be reviewed by the committee is progress in the establishment of schools for nurses and trained practical nurses in adequate numbers and reasonable locations throughout the state.

In the course of its study, the committee expects to consult with hospital administrators, nursing educators, physicians, and nurses throughout the state.

DR. J. S. DEVITT

New Law Okays Lay Health Officers

Madison, June 29.—Lay health officers may be appointed as city or county health officers in lieu of physician health officers under certain conditions.

Legislation permitting this development was passed by both Houses and signed by the Governor. Such laymen must meet training and experience requirements set up by the state board of health. Their activities must be advised and supervised by a licensed physician.

VA Limits Use of ACTH-Cortisone for Veterans

Require Prior Approval for Use of Drugs

Madison, June 15.—Physicians who treat veterans with Cortisone and ACTH must absolutely have prior approval for the use of the drugs, according to instructions issued by the Veterans Administration Regional Office in Milwaukee to the Wisconsin Veterans Medical Service Agency of the State Medical Society.

Concern over the "promiscuous use" of Cortisone and ACTH has led the VA to establish the following policy:

"We will not authorize any services to a physician who is treating a veteran with these products without having obtained prior approval for the use of the drugs. We take the position that if we authorize any services, we are in effect giving our sanction to the use of these drugs.

"We must insist upon strict compliance with the VA policy relative to Cortisone and ACTH."

Physicians who have any questions concerning this policy should contact Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency, P. O. Box 1109, Madison, Wisconsin.

Co-op Sues Duluth Medical Society

Duluth, June 15.—The Two Harbors Cooperative Health Center has charged the St. Louis County (Minnesota) Medical Society and several of its members with conspiracy to limit the services and increase the cost of medical care available in the Two Harbors community.

Two Harbors is about 28 miles northeast of Duluth on Lake Superior.

The suit asks $300,000 punitive damages of the society and its members. It charges that the society:

1. Prevented the plan from getting needed doctors by withholding membership in the medical society to doctors in the plan.
2. Deprived the plan of the services of certain consulting specialists.
3. Forced large numbers of members of the cooperative to travel to Duluth to get needed services, at direct personal expense, and at the cost of great suffering.
4. Interfered with plans to build a new hospital and clinic in Two Harbors and "intended to institute themselves or conspirators into positions of control of any new hospital that may be constructed."

The St. Louis County Medical Society and its members are fighting the suit.

The cooperative plan is being represented by Atty. Thurman Arnold, formerly head of the Anti-Trust Division of the U.S. Department of Justice under President Roosevelt, and Walton Hamilton, both of Washington, D.C. Both represented cooperatives in other suits against medical societies in Washington, D.C. and Elk City, Oklahoma.

Crownhart Elected to Fellowship in Public Health Association

Madison, May 6.—C. H. Crownhart, secretary of the State Medical Society, has been officially notified of his election as a fellow of the American Public Health Association. Mr. Crownhart is a member of the medical care section.

The American Public Health Association is a group of lay and professional people banded together at the national level for furthering public health work. It is interested in promoting studies in preventive medicine and sanitation and in prepaid medical care plans such as the Blue Shield plan of the State Medical Society.

1953

Annual Meeting Announcement

New Days! Switch from Monday–Wednesday to Tuesday, October 6, through Thursday, October 8, to fit "off day" schedules of more members.

New Program! Tie-in with official meetings of several state specialty societies. Morning programs of three or four special branches of medicine running simultaneously. Wide choice of subjects! Wonderful array of speakers! See next page.

New Entertainment! Away with long-winded and serious speeches at the Annual Dinner. Instead we will have dancing, music, high-class professional specialty acts. In short, an evening of delightful entertainment for members and wives.

On Tuesday something very special: "The Story of Medicine in Art" to be presented by the Milwaukee Art Institute during meeting. Exhibit will present paintings, medical art drawings, etc., from all over the U. S. Special reception late Tuesday, followed by buffet dinner for MDs, wives, and Milwaukee Art Institute members. Speaker *(very light)* Lejaren A. Hiller, New York illustrator and photographer.

MARK THE DATES ON YOUR CALENDAR: October 6–7–8, 1953

Special Feature *Daily Oct. 6-7-8*

DEMONSTRATION SCHEDULE

Each Morning
9:00–10:00

Direct, practical teaching in important areas of medicine. One hour of informal instruction, purposely planned for small groups. All teaching programs located on or near stage of Exhibit Hall in Milwaukee Auditorium. Get there early and enjoy this special feature of the program.

ANATOMY: The Department of Anatomy at Marquette University School of Medicine, under the direction of Walter Zeit, Ph.D., Director, will offer dissections to indicate the anatomical landmarks and hazards of a tracheotomy, and will also present a cut-away section of the spinal column, demonstrating the position of the spinal needle in a lumbar puncture.

OB & GYN: Members of the Wisconsin Society of Obstetrics and Gynecology will conduct daily manikin demonstrations to illustrate special problems of delivery, and when possible will correlate this with outstanding teaching films. Opportunities for questions and audience discussion will be provided.

FRACTURES: The Wisconsin Orthopedic Society will again demonstrate the proper application of plaster casts for fractures of the humerus and fractures about the ankle. Medical students will be used as "patients." Demonstrators will welcome a presentation of special problems by those present. The demonstrations will be under the direction of Joseph R. Stone, M.D., Milwaukee.

CEREBRAL PALSY: The Cerebral Palsy Center, Milwaukee, will present a "live" demonstration with the use of children, occupational therapists, and physicians, who will present methods of evaluation and treatment. The role of the family physician in carrying on methods of treatment on the local level will be stressed. This problem may confront you at any time, so become acquainted with modern methods of treatment and a knowledge of services available to you. Demonstrations under the direction of Raymond Waisman, M.D., Milwaukee, Director of the Cerebral Palsy Center.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present daily discussions on gross pathology, with the use of specimens of greatest interest to the general practitioner. Demonstrations under the direction of Gorton Ritchie, M.D., Milwaukee.

Only 400 Can Be Accommodated

Reserve Your Place Now

Annual Dinner "Something Different"!

This year the Annual Dinner (on Wednesday, October 7) is planned as sheer fun! No lengthy speeches . . . no long speakers' table . . . no "soup and fish" unless you like that sort of thing. In short, this event is set aside in the spirit of laughter and good fellowship. The wives have heretofore felt left out of the Smoker with its high-class professional entertainment. To meet this demand, we are turning the Smoker entertainment into the climax of the Annual Dinner.

AN EVENING OF

Fun!

Crystal Ballroom, Hotel Schroeder — **Wednesday, October 7**

5:30 p. m.: PRESIDENT'S RECEPTION

A social hour preceding the dinner where the president, the president-elect, the chairman of the Council, and their wives will meet all those who attend the dinner.

6:45 p. m.: DINNER (AND DANCING)

Steve Swedish and his band will provide the music during the dinner, and those who wish to dance between courses can do so.

8:30 p. m.: AWARDS

New members of the 50 Year Club will be honored by granting of certificates and pins.

8:45 p. m.: ENTERTAINMENT

Full hour and a half of high-class professional entertainment. Singing, acrobatic dancing, novelty acts. Those who have attended the Smoker will know what fine entertainment is provided.

---

400 LIMIT—DON'T DELAY IF YOU WISH TO ATTEND THIS EVENT

(Use Reservation Slip With Round Table Brochure)

Gue

1953 Annu

■ **JOSEPH C. AUB, M.D., Boston**

Professor of Research Medicine, Harvard Medical School

THE RELATIONSHIP OF HORMONES TO CARCINOMA: Tuesday a.m., Oct. 6

(Sponsored by Wisconsin Division, American Cancer Society)

THE METABOLISM OF BONE: Round Table, Tuesday, Oct. 6

■ ■ ■

■ **OSCAR J. BECKER, M.D., Chicago**

Assistant Professor of Maxillo-Facial Surgery, College of Medicine, University of Illinois

THE SEPTUM IN RELATION TO RHINOPLASTIC SURGERY: Thursday p.m., Oct 8

(Section on Ophthalmology and Otolaryngology)

■ ■ ■

■ **DAVID A. BOYD, JR., M.D., Rochester, Minn.**

Professor of Psychiatry, Minnesota Graduate School

ROGERS MEMORIAL LECTURE: Psychological Needs of the Medically and Surgically Ill Patient: Tuesday a.m., Oct. 6.

RECOGNITION OF THE DEPRESSED MENTAL STATE: Round Table (with Owen Clark, M.D., Milwaukee) Tuesday, Oct. 6

■ ■ ■

■ **J. BARRETT BROWN, M.D., St. Louis**

Professor of Clinical Surgery, Washington University Medical School

HOMOGRAFTS, FRESH AND POSTMORTEM, AS "BIOLOGICAL DRESSINGS" FOR BURNS: Thursday a.m., Oct. 8

SURGICAL REPAIR OF RADIATION LESIONS, INCLUDING THOSE OF ATOMIC ORIGIN: Round Table, Thursday, Oct. 8

Speakers Meeting

■ **HERMANN M. BURIAN, M.D., Iowa City**

Associate Professor of Ophthalmology, State University of Iowa College of Medicine

EVALUATION OF DIAGNOSTIC METHODS IN THE EXAMINATION OF NEUROMUSCULAR ANOMALIES OF THE EYE: Thursday p.m., Oct. 8

(Section on Ophthalmology and Otolaryngology)

■ ■ ■

■ **CONRAD G. COLLINS, M.D., New Orleans**

Professor and Chairman, Department of Obstetrics and Gynecology, Tulane University School of Medicine

VASCULAR COMPLICATIONS OF PREGNANCY: Wednesday a.m., Oct. 7.

MANAGEMENT OF PREECLAMPSIA AND ECLAMPSIA: Round Table, Wednesday, Oct. 7

NEWER METHODS OF DIAGNOSIS AND THERAPY IN OFFICE GYNECOLOGY: Wednesday p.m., Oct. 7

■ ■ ■

■ **BRIG. GEN. ELBERT DE COURSEY, M.D., Washington, D. C.**

Director, Armed Forces Institute of Pathology

THE PATHOLOGY OF HEMORRHAGIC FEVER: Wednesday a.m., Oct. 7

TISSUE REACTION TO IONIZING RADIATION: Round Table, Wednesday, Oct. 7

■ ■ ■

■ **CHARLES K. FRIEDBERG, M.D., New York City**

Assistant Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University

ELECTROLYTE DISTURBANCES OF HEART DISEASE: Wednesday a.m., Oct. 7

(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

MANAGEMENT OF INTRACTABLE HEART FAILURE: Round Table, Wednesday, Oct. 7

■ **JOSEPH H. HAFKENSCHIEL, M.D., Philadelphia**

Cardiovascular Section of the Hospital of the University of Pennsylvania

MEDICAL MANAGEMENT OF HYPERTENSION WITH PARTICULAR REFERENCE TO HYPERTENSIVE DRUGS: Wednesday a.m., Oct. 7

ETIOLOGICAL CONSIDERATIONS IN ARTERIAL HYPERTENSION AS DETERMINED BY THE SUCCESS OF CERTAIN MEDICAL OR SURGICAL PROCEDURES: Wednesday p.m., Oct. 7

■ ■ ■

■ **G. EDMUND HAGGART, M.D., Boston**

Chief of Department of Orthopedic Surgery, Lahey Clinic

MANAGEMENT OF LOW BACK AND SCIATIC BACK PAIN: Tuesday a.m., Oct. 6

(Further discussion of subject at Round Table at noon of same day)

■ ■ ■

■ **ROBERT M. JANES, M.D., Toronto, Canada**

Chairman and Professor, Department of Surgery, University of Toronto

BREAST CARCINOMA: Thursday a.m., Oct. 8
(Sponsored by Milwaukee Division, American Cancer Society)

ROUNDED SHADOWS IN THE CHEST: Thursday p.m., Oct. 8
(Closing General Session)

■ ■ ■

■ **O. P. KIMBALL, M.D., Cleveland**

Chief of Medical Staff, Doctors Clinic, Cleveland, Ohio

THE GENETICS OF EPILEPSY: Thursday a.m., Oct. 8

EPILEPSY IN RELATION TO INHERITANCE: Round Table, Thursday, Oct. 8

■ **TRAIAN LEUCUTIA, M.D., Detroit**

Assistant Professor of Radiology, Wayne University

COMPARATIVE EVALUATION OF DEEP ROENTGEN THERAPY AND SUPERVOLTAGE ROENTGEN THERAPY: Thursday a.m., Oct. 8

PLESIOTHERAPY AND TELETHERAPY WITH VARIOUS RADIOACTIVE SOURCES: Round Table, Thursday, Oct. 8

NEWER DEVELOPMENTS IN RADIATION AND CHEMOTHERAPY FOR THE TREATMENT OF CANCER: Thursday p.m., Oct. 8

(Closing General Session)

■ ■ ■

■ **WILLIAM O. McQUISTON, M.D., Peoria, Ill.**

Instructor in Surgery, Northwestern University

ANESTHESIA FOR CARDIAC SURGERY: Tuesday a.m., Oct. 6

PEDIATRIC ANESTHESIA: Round Table, Tuesday, Oct. 6

■ ■ ■

■ **JOHN W. PENDER, M.D., Rochester, Minn.**

Assistant Professor of Anesthesiology, Mayo Foundation

GENERAL ANESTHESIA FOR THE PATIENT WITH CARDIAC DISEASE: Tuesday a.m., Oct. 6

COMPLICATIONS IN ANESTHESIA RELATED TO CORTISONE THERAPY: Tuesday p.m., Oct. 6

■ ■ ■

■ **MILTON J. E. SENN, M.D., New Haven, Conn.**

Sterling Professor of Pediatrics and Psychiatry, Yale University, and Director, Yale University Child Study Center

THE VALUE OF THE CHILD GUIDANCE CLINIC TO THE PRACTICING PHYSICIAN: Round Table, Thursday, Oct. 8

WHAT THE FAMILY PHYSICIAN SHOULD KNOW ABOUT EMOTIONAL PROBLEMS OF CHILDREN: Thursday, Oct. 8

(Closing General Session)

■ **PAUL L. SHALLENBERGER, M.D., Sayre, Pa.**

Clinical Professor of Medicine, Hahnemann Medical School, Philadelphia, Pa.

LESIONS OF THE LOWER COLON: Tuesday p.m., Oct. 6

PEPTIC ULCER: Round Table, Wednesday, Oct. 7

■ ■ ■

■ **WILLIAM M. TUTTLE, M.D., Detroit**

Associate Professor of Clinical Surgery, Wayne University

SURGICAL MANAGEMENT OF UNRESOLVED PNEUMONIA: Wednesday a.m., Oct. 7

(Sponsored by Wisconsin Anti-Tuberculosis Association)

DIAGNOSTIC DIFFICULTIES IN CARCINOMA OF THE LUNG: Round Table, Wednesday, Oct. 7

THORACIC TRAUMA: Wednesday p.m., Oct. 7

■ ■ ■

■ **LAWRENCE R. WHARTON, M.D., Baltimore**

Assistant Professor of Gynecology, Johns Hopkins University

UROLOGIC COMPLICATIONS IN OBSTETRICS AND GYNECOLOGY: Wednesday a.m., Oct. 7

NON-OPERATIVE TREATMENT OF STRESS INCONTINENCE IN WOMEN: Wednesday p.m., Oct. 7

■ ■ ■

■ **WILLIAM T. GREEN, M.D., Boston**

Clinical Professor of Orthopedics, Harvard Medical School

RECONSTRUCTIVE SURGERY IN POLIOMYELITIS: Tuesday a.m., Oct. 6

(Sponsored by National Foundation for Infantile Paralysis)

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Reactions to Antibiotics

According to Rutenburg and Pinkes,[1] the orange-colored antibiotic aureomycin produces a positive test for bilirubin in the blood, indicative of damage to the liver. This test reaction rather quickly disappears on cessation of the medication. That the pigmentation is due to alteration of hepatic function rather than to the tinctorial property of the drug is indicated by the fact that the abnormal values for bilirubin in the blood may run parallel to bromsulfalein retention, as an indication of hepatic damage. Fortunately, the signs or indications of abnormal hepatic function generally disappear within two or three days after administration of the aureomycin has been discontinued.

Another series of observations[2] on the effects of aureomycin or of Terramycin points to the complicating liabilities arising from the development of an abnormal bacterial flora within the gastrointestinal tract. For a considerable time, reports have been appearing concerning the usefulness of certain antibiotics in the treatment of amebic dysentery. The general consensus of investigators, in regard to the mode of action of effective antibiotics in this disease, is that the drug alters the intestinal flora in such a manner that even benign amebae cannot readily survive. Perhaps the bacteria on which amebae depend are so inhibited that growth of these amebae essentially ceases. Views are now being reported to the effect that there is also a bacterial imbalance in the gastrointestinal tract which could deprive the amebae of those special bacteria which supply their nutritional necessities. Also a concurrent, unhindered overgrowth of micrococci occurs, which in turn can cause toxemias. Thus it would appear that members of the colon group of bacteria such as Escherichia coli, together with members of the Proteus group, cease to offer effective competition to the micrococci, which then multiply in a more or less uncontrolled fashion and thereby become responsible for these toxemias. Added to the feature of micrococcal overgrowth is the likelihood that these same organisms will develop their own resistance to the antibiotics.

A diarrhea developing in a patient receiving aureomycin or Terramycin constitutes a danger sign. Smears of stool material stained by Gram's staining method must be made and if Gram positive organisms dominate in the bacterial flora, the drug must be stopped immediately. Postponing the treatment until a culture is developed may be too late, since the patient may die in the meantime. It is suggested that erythromycin be given orally, since this drug is said to inhibit micrococcal growth with only negligible effects on the coliform bacilli. The signs and symptoms of micrococcal dominance are diarrhea, shock, anuria, and uremia. Immediate cessation of the use of Terramycin or of aureomycin is imperative in this condition.

Fatal consequences following the complications due to sensitivity to penicillin are reported by Siegal.[3] While such serious reactions are not frequent, they do occur and it must be remembered that their infrequency does not make death itself any the less tragic.

This remarkable drug, penicillin, with its outstanding record of usefulness, furnishes a most noteworthy example of the author's statement that any drug may have a Jekyll–Hyde personality. The drug is positively outside the category of normal physiologic substances and is therefore a foreign material.

The marvel is not that penicillin and other drugs can lead to tragedies, but rather that up to now such tragedies are relatively rare. They are almost certainly to be expected with increasing frequency, since the extremely widespread spectrum of usefulness of penicillin, which perhaps very often is not even really needed, can be expected to lead to increased use and to the sensitization of more and more people through its administration by physicians, or through self-medication. As intimated above death is much the same regardless of who is respon-

sible for the unjustified uses and consequent liabilities.—A. L. TATUM, M.D.

REFERENCES

1. Rutenburg, A. M., and Pinkes, S.: The hepatotoxicity of intravenous aureomycin, New England J. Med. 247:797–800 (Nov. 20) 1952.
2. Stilwell, G. G.: Fatal enterotoxic reactions caused by antibiotic therapy, Minnesota Med. 36:63–64 (Jan.) 1953. (Editorial report)
3. Siegal, S., Steinhardt, R. W., and Gerber, R.: Fatal and near-fatal penicillin anaphylaxis; three new cases with a note on prevention, J. Allergy 24: 1–10 (Jan.) 1953.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 37 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWG	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:45 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Environmental Sanitation and Disease Control

As It Looks to Your State Board of Health

DURING the past half century much has been accomplished in improving the healthfulness of homes and communities, so that today we assume that our complex environment is safer, by and large, than our ancestors'. For example, no longer do we suffer from the large-scale outbreaks of typhoid fever, dysentery, and gastroenteritis that were so prevalent at the turn of the century. The incidence of typhoid fever and dysentery in this state is now so low that many people are inclined to minimize the need for maintaining and strengthening controls.

But we are by no means freed from all health dangers and hazards of our environment. Pollution of our air, drinking water, and food; unnecessary spoilage of our lakes and streams; and basic defects of our shelter still need to be controlled through the advancement of science and research, the application of principles of sanitation to these health hazards, and the education of individuals. It is important that the hazards be recognized.

Records of the board indicate that the death rate due to diarrhea-enteritis (under two years) and the incidence of typhoid fever is higher in rural than in urban areas. This in part can be attributed to poorer water supply and sewage disposal systems as well as to less exacting requirements in other environmental areas.

Part of the problem has been created by the change from city dwelling to rural-city dwelling. The city dweller who had his household sewer connected to a municipal system for central treatment loses "sewer rights" upon leaving the community and is confronted with the installation of a private system. All too often soil conditions are subsequently found to be unsuitable for absorption of the septic tank effluent, and building lots are inadequate in area to increase absorption facilities materially. Thus nuisances and public health hazards are created by overflowing seepage pits and sewage flowing in roadside ditches, into dry runs, or into farm drainage tile and storm sewer systems.

The solution of this problem demands more than modern sanitary engineering. This is a modern problem requiring the teamwork of governmental agencies and all the people in the metropolitan community. There is no doubt that a solution or solutions will be found.

A major problem also in other areas of environmental health is the tendency to accept the status quo, to assume that the present level of activity for cleanliness at the individual and community level is adequate to maintain a low incidence of food- and water-borne disease. This supposition is fraught with danger in view of the lowered immunity to such diseases and because of the ever-increasing population. Although the sanitation of public restaurants is supervised on a state-wide basis by the State Board of Health, there are many occasions when food is served to groups which do not come under their jurisdiction, such as at picnics and group suppers. Most outbreaks have been caused by serving perishable foods which, after contamination, had been allowed to stand at room temperatures. Here modern refrigeration is particularly effective in preventing the growth of dangerous numbers of bacteria.

It is known that food and food utensils can be contaminated with bacteria, parasites, or poisons. Food or utensils may carry the germs of brucellosis, typhoid, paratyphoid, scarlet fever, diphtheria, salmonellosis, septic sore throat, and a variety of other disorders.

It is difficult to assess the danger of contaminants in food because at present there is no way to check thoroughly the number, frequency, and sources of cases of food-borne disease except in institutions. But defenses can be set up. Attention to proper sanitation by everyone involved in food processing and preparation is needed. Rodent and insect control is an essential part of this sanitation.

The effects of over-crowding in housing, accidents in the home, air pollution in our cities, and spoilage of our lakes and streams all present problems in disease prevention that need continuing study. We still need a green light on improvements in cleanliness and care in our environment.—O. J. MUEGGE, *State Sanitary Engineer.*

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

HOME AND ● OFFICE ● PROCEDURES

62265

1. WPS Claim No. Plan Code No.

Last Name First Name Initial

2. Patient

3. Group No. 4. Contract No.

5. Subscriber's Name

Street and Number

City and State

6. Patient's Age Sex 7. Patient is:

Subscriber ☐

Subscriber's Spouse ☐

Unmarried Child Under 19 ☐

PHYSICIAN'S SERVICE REPORT

WISCONSIN PHYSICIANS SERVICE

Blue Shield

"THE DOCTORS PLAN"

704 East Gorham Street

Madison 3, Wisconsin Phone 6-3101

8. Were Services: Surgical ☐ Maternity ☐ Medical ☐ Anesthesia ☐ X-Ray ☐ Other

9. Where Did You Render the Services: Hospital In-Patient ☐ Hospital Out-Patient ☐ Office ☐ Home ☐

10. Name of Hospital IMPORTANT

City 11. Admission Date 12. Discharge Date

13. DIAGNOSIS AND COMPLETE DESCRIPTION OF SERVICES YOU PERSONALLY RENDERED | DATE | CHARGE

How to Bill for Non-Hospitalized Cases

Recently every member of the State Medical Society was provided with a supply of Physicians Service Reports (PSRs) of the type shown above.

These PSRs are to be used only for reporting surgical or maternity services rendered outside the hospital. **Do not use these forms to report home and office calls.**

The WPS Blue Shield contract does not provide benefits for home or office visits as those terms are commonly accepted. WPS does provide benefits for surgical or maternity services, as defined in the contract, when they are rendered in the home or office. The physician should use the above form for reporting these services for payment.

Billing for non-hospitalized cases will be simplified and payment speeded if the physician or his office personnel obtain the following information from the patient's Blue Shield Identification Card and report it on the PSR:

1. Subscriber's name (Be sure to report the patient's name also, even if it is the same as the subscriber's.)
2. Contract, group, and code numbers.

Be sure to list the name of the patient and the date of treatment. Check the type of service rendered. Describe adequately the services performed for the patient. The physician who performed the services must sign the PSR. A separate report must be completed by each doctor for his services, if there is more than one physician on the case.

After completing the form, the third carbon copy should be torn off and kept for the physician's file. Leave all other carbons and copies intact and mail to Wisconsin Physicians Service.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 JULY 1953 Number 7

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point

R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

The Razor's Edge

There were three ahead of me when I walked into the barbershop last Saturday. "About an hour," the barber said. I was on vacation, so I waited.

I was just starting a good Post feature when I was conscious of some comments about doctors. ". . . Dr. McCormick . . . A.M.A. . . . overcharging . . . better service . . ." Maybe I ought to eavesdrop, I decided.

"See where the new A.M.A. president thinks it's unfortunate that so many people believe all doctors charge too much," the dirty overalls man read from the local paper. "Wonder what else we should think? Did you read about this tax case where the government is checking up on some doc who paid only $30,000 in taxes when he should have paid $80,000? If you want to see something once, you should take a ride up to the north side of town where all that building is going on. Four houses in a row, all doctors, and not a one under 30,000 bucks. I know, my brother worked on two of them."

The local preacher broke in—I knew he was a preacher because they called him Reverend—"There's no question that people think all doctors make a mint of money. But they deserve a good living for all their education and skill and they're always on call."

"Did you ever try to get a doctor at night for your kids, Reverend?" the barber broke in. "You're lucky if you can get hold of one, much less get him to the house. Why don't they leave word with somebody where they'll be or who to get hold of?"

I was just about to break in with a suggestion that the barber ought to make arrangements with a family doctor about such things, but he beat me to it: "A man can hardly get in to see the doctor anymore without waiting two, three hours. My time's worth money too. When you do get in, it's bing, bang, here's your prescription, next please. Remember how old doc used to take a couple minutes to find out how things were, talk to you, I mean. He was really good at diagnosing."

A younger fellow in a white shirt started in then. "I'm not blaming them, but I'm not defending them either. Doctors are busy. So we're all busy. Just a little business sense would do them a lot of good, though. Every bill you get from a doctor says 'for professional services.' That lump sum looks mighty big. No wonder people think doctors overcharge. If they'd just itemize bills, like I do—"

With a flourish the barber pointed his scissors my way—as if I were the guilty party. "I think it's a crime the way some doctors boost the ante when they find out you've got health insurance. No wonder the premium rates are so high. That's what brings on socialized medicine, if you ask me."

Another fellow spoke up: "I'm against socialized medicine no matter what you call it, but I sure get burned up at some of these smart-alecky office girls doctors have got. They want to know all about why you want to see the doctor—right in front of everybody. What's it to them?"

"The A.M.A. can run all kinds of ads and pass all the resolutions it wants to, but people aren't going to sympathize with doctors until doctors have a little more sympathy for patients," declared the white-shirted man. "Expensive operations and high-priced drugs are needed, I suppose, but some of the cheapest medicine is a smile and a little understanding explanation of what might be wrong. And it does more good. I think a guy has a right to know about what an operation or treatment is going to cost him, without the doctor saying 'don't worry about that.' I *gotta* worry about it.

"And a fella ought to feel that if he needs a doctor some time he can get one in a hurry when it's necessary. If you only knew what to do at a time like that. Another thing, seems to me too many doctors slam each other. Just the other day I went to one doctor who said he couldn't figure out how my other doctor had any patients at all the way he works. Didn't say why—just that remark. That doesn't sound much like a professional man. Wonder what he tells people about me."

"Next," said the barber. "Who's next?"

I jumped. That was me. A few minutes later, as he started shaving my neck, I wondered what he would say if he knew I was a doctor.

Nurse Recruitment

Anyone familiar with the nursing shortage is cognizant of the fact that nurse recruitment is a must if we are to keep our hospitals open. In the past several committees have worked on the subject. The complexities which developed when they dealt with hospital administrators, with the Board of Nursing Education, with those in favor of practical nurses and those not in favor of practical nurses, and with those in favor of raising the standards vs. those in favor of lowering the standards have made most of the committees throw up their hands in horror and declare the whole thing an impossible job.

The Woman's Auxiliary to the Medical Society then took up the job of nurse recruitment. The results they have accomplished in the last few months should make us mere males gasp with astonishment. The Board of Nursing Education, our Auxiliary, and even the hospital administrators are working hand in hand. Not only has oil been copiously used on troubled waters but the oil seems to be mixed with a trace of honey. Scholarships have been set up throughout the state and every high school has been given brochures explaining nursing as a vocation. The publicity given this program by the newspapers of Wisconsin is almost phenomenal.

So hats off to the Auxiliary and the job they are doing on nurse recruitment. Our apology to you collectively for not asking your help sooner in one of our most difficult problems, knowing right well that as individuals your help is always given unselfishly every day.

Dextran Replaces Plasma

Recent executive orders from both the Army Medical Corps and the Veterans Administration have ordered that henceforth dextran, a substance made from sucrose, will replace blood plasma for all medical requirements. Undoubtedly, these same orders will follow through for the other armed services and the public health services.

The reason given for this change is that dextran has been tested long enough both in Sweden, as reported by Thorsen in 1949, and in the armed services in this country so that there is no question about its efficacy when used as a plasma expander. This is accomplished without exposing the patient to the danger of virile hepatitis and without interfering with his body functions.

Several drug houses are already in production on dextran and it is available commercially in almost every hospital. This writer is in complete sympathy with this change-over and will heartily agree that from the evidence at hand it seems perfectly justifiable. The only thing for all of us to remember is that plasma expanders are only temporary expedients and that there is as yet no satisfactory substitute for blood in the treatment of traumatic shock. It is doubtful whether any substance will ever be discovered that compares to blood when it is used for this purpose. Let us hope that the enthusiasm for dextran will not overshadow and minimize the necessity for maintaining our blood banks throughout the country to continue to supply the armed forces with blood.

. . . . THE PRESIDENT'S PAGE . . . .

A Victory for Public Health

IF EVER there was proof that sound legislative action can make significant contributions to the public health and welfare it was the 1953 session of the Wisconsin legislature. The lawmakers fought some very bitter battles on behalf of public health, and triumphed. Because the legislative process couldn't keep up with the vast number of bills handled in the two days before the recess, it remains to be seen whether the health measures passed in both houses will be signed into law by the Governor.

More than 1500 bills went into the legislative hopper and one out of 10 had some public health implication. The legislative program of the State Medical Society won approval—though not without a fight. The net effect of the session's activities can be summed up in three points:

1. Modernization and improvement of the state's medical practice act.
2. Greater number of physicians because of increased medical school facilities, and elimination of certain technical barriers to licensure of qualified physicians.
3. Protection of the public from quackery and cultism.

Revision of the medical practice act, which had not been thoroughly reviewed for more than half a century, was the result of a year-long study by the Public Policy Committee. The rewards of their effort are sure to be seen and felt in more efficient administration of the Board of Medical Examiners in Madison offices. Annoying and burdensome requirements for registration of physicians with county clerks have been eliminated. Quarterly meetings of the board and improved reciprocity arrangements will make it easier for competent applicants to be licensed in Wisconsin. The legislature plugged several loopholes that have permitted charlatan faith healers and unscrupulous limited licensees to prey upon the unsuspecting public.

Temporary educational certificates will be available to as many as 25 foreign-graduated medical students each year to permit them to take postgraduate work in approved teaching hospitals. This move will ease the need for residents in Wisconsin hospitals while offering the benefits of our educational system to our less fortunate friends abroad.

Other bills assure adequate reciprocity arrangements with the armed forces and the National Board of Medical Examiners in the basic sciences. Both houses passed a Society-backed measure for a $2,800,000 medical school addition to provide adequate facilities for pre-clinical training at the University of Wisconsin. Presumably the facilities would increase the output of physicians from about 80 to 110 annually. Since then the Governor has vetoed the measure, but the entire problem will be studied during the summer.

Every cultist bill that threatened public health was defeated. The chiropractors presented five major bills aimed at expanding their field of practice by sugar-coating their limited training and skill. The naturopaths surged into the legislature with great ballyhoo about competent training, their success where other practitioners had failed, and their Communist-like subjugation. They were exposed as cultists against almost everything but "lettuce and spinach." Some masseurs and naturopaths, frightened that their inadequacies and law violations might be discovered, fought viciously to prevent the licensing of highly trained and well-qualified physical therapists.

The Medical Society may well be proud of its part in the achievements of this legislature. High praise is due those legislators whose sense of public responsibility remained steadfast in the face of relentless and almost unprecedented cultist pressure. The people of Wisconsin, including the physicians, may contemplate with satisfaction the work of the 1953 legislature in the interest of better health.

J. C. Griffith M.D.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Recruiting for Medical Fields

The Wisconsin Medical Society has launched a campaign to attract young people coming out of our high schools and colleges into nursing and related fields.

The society declares that Wisconsin could use three or four thousand more nurses than are now available, and that jobs could be provided for twice as many physical therapists as there now are. Health inspectors are notoriously scarce, and workers in that field contend that its personnel could easily be increased by 100 per cent if qualified people were available.

These are but two examples. The usual reason given for the lack of interest in these fields of public service is comparatively low monetary return for service rendered. No one can quarrel with those reasons, but it goes without saying that there are other reasons which make this one valid . . .

In other words, we as a nation are paying such a price for our luxuries that we can no longer afford such necessities as education and nursing care. Sooner or later—and it looks like sooner—our topsy-turvy sense of values is going to throw us for a loop. —Marshfield News-Herald, May 27, 1953.

* * *

Let's Start Housecleaning

Here's a mailing piece from the American Medical Association, commenting on the threat of socialized medicine. We'll go along with the medicos that socialized medicine would be strictly NG for more reasons than we care to list here, but unless the MDs of the nation start controlling the fees they charge and get that phase of their operation somewhere within reason, they will be more responsible for the advent of socialized medicine than anyone.

Charges in a city like Hartford are, as a general rule, held within reason, but we object violently to the sliding scale used quite generally by doctors in charging what the traffic will bear. In other words, charges are made on many occasions according to the ability of the patient to pay. We say that a tonsillectomy or an appendix operation or anything else is a pretty standard matter and should cost the same for everyone. It does not, however, and medicos have openly admitted it to us. That, and excessive charges for persons who are in a position to pay, jeopardize the whole structure of medicine. So let's start the housecleaning where it is needed, and then worry about the threat of socialized medicine.—Hartford Times-Press.

* * *

Miracle in Short Supply

Medical science now has at hand gamma globulin —which . . . will, when given to exposed persons before symptoms occur, prevent poliomyelitis in a large number of instances and modify its severity in others.

Gamma globulin cannot be used in the wholesale manner suggested by the successful war on smallpox for the simple reason there is not enough of it to go around . . .

Restricting the use of gamma globulin largely to children under 19 is sound and practical . . . The recommended quantity for use in prophylaxis is 0.14 cc. per pound of body weight. Thus five children under four years of age could be immunized for each adult . . .

The State Medical Society and the State Board of Health are making serious efforts to defend against the expected summer attack of polio. The cooperation of all of the people and all of the physicians is necessary to win this battle for the children.—Green Bay Press-Gazette, May 19, 1953.

* * *

Calling All Doctors!

Milwaukee doctors who play hookey from their practices to go to ball games will be spared the embarrassment of having that fact made known to 20,000 or 30,000 people. The Milwaukee County Medical Society announced this week that it has assigned a number to each member doctor, and at public gatherings when a doctor must be called away for an emergency, he will be paged as "Doctor 25," or "Doctor 28," etc.

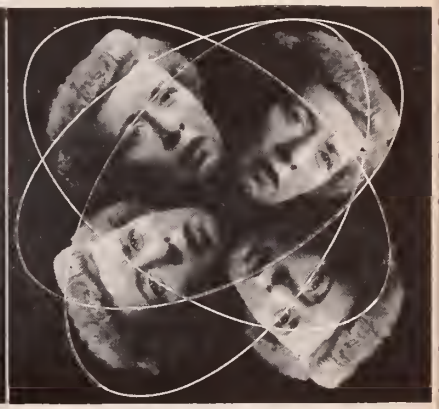
Officers of the medical society, announcing the new system, dispensed with any face-saving talk about efficiency and frankly admitted that the purpose is to "eliminate unnecessary embarrassment on the doctor's part."

. . . Now a doctor can go out to watch the Braves, clothed in a sport shirt and anonymity, responding only to a number. Progress marches on!—Racine Journal-Times, May 26, 1953.

1

1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*

2



3

TYPES OF VERTIGO:

Their symptomatic relief with Dramamine®

The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

Dramamine (brand of dimenhydrinate) has proved effective in treating many of these disturbances. The indications for which Dramamine is now Council accepted include: Motion sickness, the nausea and vomiting associated with pregnancy, certain drugs, electroshock therapy and narcotization; vestibular dysfunction associated with streptomycin therapy; the vertigo of Ménière's syndrome, hypertensive disease and that following fenestration procedures, labyrinthitis and radiation sickness.

1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

SEARLE *Research in the Service of Medicine*

COMMITTEE *Concentrates*

DIVISION ON PUBLIC ASSISTANCE
MAY 21

MDs present: H. W. Carey (chairman), E. W. Schacht, W. K. Simmons, C. M. Carney, C. A. Olson, L. F. Morneau, T. W. Tormey, Jr. (chairman, Commission on State Departments).

The Division's first meeting was primarily to acquaint its members with the problems to be encountered and projects to be undertaken in public assistance programs . . . Mr. Lucas and Mr. Lawver of the State Department of Public Welfare pointed out that the greatest problem of that state agency is the variation between counties as to costs, restrictions, and policies regarding method of authorization for care and the extent of it . . . Division recommended that efforts be made for greater cooperation between medical directors of county institutions and county medical societies for appointment of advisory committees to review matters of medical policy . . . recommended as joint effort with state agency a comparative study of fee schedules and policies between all counties, improvement of liaison between county medical societies and welfare groups, and investigation of different methods for directing welfare programs.

AUDIT AND BUDGET COMMITTEE
MAY 23

MDs present: E. M. Dessloch (chairman), A. J. McCarey, J. M. Bell, N. J. Wegmann, J. C. Fox, J. C. Griffith, H. Kent Tenney.

The committee reviewed the audit of the Society's financial affairs for 1952 and reported to the Council its commendation for a comprehensive and satisfactory audit showing the Society affairs to be in sound condition . . . appropriated an expenditure to the Section on Radiology for one half the cost of replacing viewboxes . . . appropriated an additional amount in connection with the special art exhibit to be presented at the annual meeting, in cooperation with the Milwaukee Art Institute . . . authorized the purchase of two window units for air conditioning on the third floor of the Society building.

INTERIM COMMITTEE
MAY 23

MDs present: J. C. Griffith (chairman), R. G. Arveson, S. E. Gavin, J. C. Fox, J. M. Bell.

The committee reviewed in detail with representatives of the Provident Life & Accident Insurance Company provisions and procedures of the group disability plan, and recommended to the Council changes in coverage and administrative procedures for the new policy year beginning in August 1953 . . . recommended to the Council consideration of a special membership for physicians who are engaged in full-time teaching in the basic sciences and are not engaged in active practice . . . recommended a change in the By-Laws to provide for automatic revocation of membership in the Society when a physician's license to practice has been suspended . . . recommended as delegates to the Student AMA meeting in Chicago Drs. J. S. Devitt, Milwaukee, and C. G. Reznichek, Madison.

DIVISION ON REHABILITATION
MAY 26

MDs present: R. G. Piaskoski (chairman), P. J. Collopy, E. P. Roemer, J. G. Beck, C. C. Gascoigne, T. W. Tormey, Jr. (chairman, Commission on State Departments).

At its first meeting, the Division reviewed with Mr. John Kubiak problems confronting the state agency, to determine how it could be of assistance in meeting medical problems associated with rehabilitation work in Wisconsin . . . recommended to the Commission on State Departments the appointment of a special fee committee, within the Commission, to study present schedules and their revision . . . authorized a study of specific items on present schedules causing concern to the Rehabilitation Division and physicians . . . recommended that the Society's Division on Rehabilitation be accepted as the medical advisory committee to the Rehabilitation Division of the State Board of Vocational and Adult Education . . . will undertake as a major project the education of physicians and the public as to facilities available through the Rehabilitation Department and procedures for their utilization.

A Marked Advance in

oral estrogen therapy

no odor or after-odor

no taste or aftertaste

Now, after years of search . . . a *pure* crystalline salt of the conjugated natural estrogen, estrone.

HOW has this tasteless, odorless therapy shown in clinical trial?..."The facility with which dosage can be regulated . . . and the rapidity with which relief can be obtained on minimal medication are commendable."[1]

SIDE EFFECTS? From a report on 58 standardized menopausal patients . . ."Nausea was extremely uncommon, being observed in only . . . one patient on Sulestrex."[2]

ESTHETIC? "The annoying urinary taste and odor, sometimes found in natural conjugated estrogen, is not present."[3] Make *your* test of SULESTREX—soon. Available in Tablets and Elixir.

Abbott

SULESTREX® Piperazine

(Piperazine Estrane Sulfate, Abbott)

1-1878

1. Reich, W.J. et al. (1951, A Recent Advance in Estragenic Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 2. Perlaff, W.H. (1951), Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 3. Reich, W.J. et al. (1952), A Recent Advance in Estragenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY
MAY 28

MDs present: J. S. Supernaw (chairman), James Moffett, William Fischer, Otto Dittmer, S. E. Sebastian, E. O. Ronneburger.

The committee reviewed cases presenting special problems . . . A survey of claims submitted by physicians showed that 72 per cent of them were under $10 and only 2 per cent were over $40 . . . A lack of complete medical information on the forms being sent to the VA was demonstrated by an examination of a number of cases . . . Two or three contract changes were discussed and will be taken up with the Washington office of the VA.

DIVISION ON SCHOOL HEALTH
JUNE 3

MDs present: E. H. Pawsat, A. H. Heidner, W. R. Manz, T. W. Tormey, Jr., H. Kent Tenney,

Conference on "Physicians and Schools" held in 1952 evaluated, and preliminary plans made for regional follow-up conferences which may be held in 1954. Plan to use state colleges as sites wherever possible. Subject material and speakers discussed, with final plans to be made by smaller committee during current year . . . Evaluated material on First Aid Kit for handbook prepared by State Board of Health and made available to all schools . . . Approved survey to evaluate current health practices in schools. Survey to be made in late summer or early fall, with State Board of Health tabulating returns . . . Recommended that "March of Medicine" broadcasts give special emphasis to school health matters at certain times during the year . . . Recommended that the medical aspects of the W.I.A.A. program be incorporated as a function of the Division on School Health, leaving all insurance parts of the program under the supervision and review of the Commission on Prepaid Plans.

MATERNAL MORTALITY STUDY
JUNE 6

MDs present: T. A. Leonard, J. W. Harris, Alice D. Watts, R. J. Sanderson, E. D. Wilkinson, George Hank.

Reviewed cases based on interviews and discussed policies regarding certain cases which might not warrant interviews but should be included in over-all study. Decided to add to interviewers by asking the following to participate in the study: Dean D. Willson, Fond du Lac; Donald Britton, Frederick A. Brown, Carl S. Harper, David L. Williams, Edwin F. Schneiders, and Lee B. Stevenson, Madison; Benjamin E. Urdan and John W. R. Thoma, Milwaukee; Elizabeth A. Steffen and Leo Grinney, Racine.

GRIEVANCE COMMITTEE
JUNE 13

MDs present: R. E. Fitzgerald (chairman), E. W. Mason, F. A. Nause, E. D. Sorenson, H. W. Wirka.

CHICAGO MEETING PLANNED BY AMERICAN COLLEGE OF SURGEONS

More than 11,000 surgeons, other physicians, and guests are expected to attend the 39th annual Clinical Congress of the American College of Surgeons to be held in Chicago, October 5 through 9, 1953.

Surgical technics and new developments in surgery will be covered in this five-day meeting. The program will include formal scientific papers, panel discussions, symposia, postgraduate courses, surgical forums, medical motion pictures, ciné clinics, color television, and exhibits. Headquarters will be at The Conrad Hilton Hotel.

For further information write to the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN NEW YORK IN SEPTEMBER

The 18th Annual Congress of the United States and Canadian Sections of the International College of Surgeons will open at the Waldorf-Astoria in New York on Sunday evening, September 13, with a session open to the public on the "International Surgeons' Hall of Fame." Dr. Richard H. Shryock, Director of the Institute of the History of Medicine of Johns Hopkins University, Baltimore, will speak on "Fame in Surgery." The scientific program will open on Monday morning, September 14. The Congress closes with the annual convocation during the evening of September 17.

For further information write to the International College of Surgeons, United States Chapter, 1516 Lake Shore Drive, Chicago 10, Illinois.

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY-MANSFIELD DIVISION

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Oshkosh, October 9, 1952:

Name	*School of Graduation*	*Year*	*Address*
Ageloff, Harry	Columbia	1937	610 Sixth Street, Racine
Carey, E. S.	Rush	1924	2602 E. 74th, Chicago, Ill.
Deering, H. C.	Chicago	1949	1240 W. Windlake, Milwaukee
Fauley, G. B.	Northwestern	1930	6370 N. Nokomis Avenue, Chicago, Ill.
Fuller, Josiah	Harvard	1943	1527 Third Avenue, S. W., Rochester, Minn.
Hart, G. M.	Northwestern	1944	216 Arcade Building, Racine
Himmelsbach, William	Georgetown	1945	1707 Main Street, La Crosse
Jaeck, J. L.	Minnesota	1937	1903 S. 22nd Street, La Crosse
Miller, W. C.	Loyola	1937	Box 86, Racine
Norton, R. G.	Iowa	1945	2414 Waco Street, San Angelo, Texas
O'Connor, R. E.	Marquette	1946	310 N. Orchard, Madison
Scarlett, Thomas	Temple	1936	Sacred Heart Hospital, Allentown, Pa.
Semler, W. L.	Wisconsin	1949	3606 N. Sherman Boulevard, Milwaukee
Silberman, Jack	Chicago	1951	2114 N. Seventh Street, Milwaukee
Tucker, A. S.	Yale	1939	1964 Wyandotte Road, Cleveland, Ohio

The following physicians were granted licenses at the October 1952 meeting of the State Board of Medical Examiners:

Name	*School of Graduation*	*Year*	*Address*
Callahan, J. W.	Marquette	1951	7209 W. Leon, Milwaukee
Heiser, P. A.	Northwestern	1951	1238 N. Franklin, Chicago, Ill.
Jeffers, D. H., Jr.	Marquette	1951	824 Geneva, Lake Geneva
Jermain, L. F.	Marquette	1951	3423 N. Maryland, Milwaukee
Keppler, L. L., Jr.	St. Louis	1951	Milwaukee Children's Hospital, Milwaukee
McDonald, D. H.	Marquette	1951	Winneconne
McKenna, Patricia S.	Northwestern	1952	125 Vaughn Court, Madison
McKenna, R. D.	Northwestern	1951	125 Vaughn Court, Madison
Uhley, H. N.	Wisconsin	1951	3150 N. 44th, Milwaukee
Wagner, R. J.	Marquette	1947	914 S. Eighth Street, Minneapolis, Minn.

At a meeting held in Madison, January 13–15, 1953, the following physicians were granted licenses by the State Board of Medical Examiners:

Name	*School of Graduation*	*Year*	*Address*
Bleil, D. C.	Marquette	1951	1555 N. 51st, Milwaukee
Block, D. L.	Wisconsin	1951	9596 Greenview, Detroit, Mich.
Chong, Elaine K. K.	Woman's Medical College, Pennsylvania	1951	Milwaukee Children's Hospital, Milwaukee
Draheim, J. H.	Minnesota	1949	Gorgas Hospital, Ancon, Canal Zone
Gruhl, Helen V. D.	Wisconsin	1951	2731 E. Beverly, Milwaukee
Kearns, W. M., Jr.	Johns Hopkins	1947	3641 N. Hackett, Milwaukee
Lee, J. M.	Virginia	1951	Wisconsin General Hospital, Madison
Lodge, J. H.	Johns Hopkins	1951	425 Lorch Street, Madison
Longe, W. G.	Marquette	1951	8904 W. Bluemound, Milwaukee
Lucas, P. M.	Marquette	1951	3209 S. Ninth Place, Milwaukee
Malcolm, Virginia N.	Marquette	1950	3018 N. Stowell, Milwaukee
Miller, C. O	Marquette	1951	2445 N. 41st, Milwaukee
Oertley, R. E.	Iowa	1951	1020—18th Avenue, Monroe
Ousley, J. L.	Chicago	1951	31-F University Houses, Madison
Pfeifer, Grace E.	Northwestern	1951	3701 Kinzie, Racine
Quetsch, R. M.	Loyola	1951	905 S. Vine Avenue, Marshfield
Schechter, J. J.	Northwestern	1951	2021A N. 21st, Milwaukee
Schuster, D. S.	Wisconsin	1951	2722 Van Hise, Madison
Thurow, R. M.	Marquette	1949	United States Naval Hospital, Great Lakes, Ill.

The following physicians were granted licenses by reciprocity at the January 14, 1953, meeting in Madison of the State Board of Medical Examiners:

Name	*School of Graduation*	*Year*	*Address*
Apple, V. H.	Michigan	1948	Valders
Autrey, W. A.	Minnesota	1951	215—32nd Avenue, N., St. Cloud, Minn.
Banker, R. J.	Northwestern	1948	1037 N. 17th Street, Manitowoc
Beyer, J. A.	Columbia	1945	1921 University Avenue, Madison
Briggs, J. P.	Wayne	1948	124 N. James Street, Waukesha

(Continued on page 28)

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

SENILE

For further information—
G. R. Love, M. D.
Oconomowoc, Wisconsin

RADON SEEDS

FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

THE RADIUM EMANATION CORPORATION
GRAYBAR BLDG. Telephone MU 3-8636 NEW YORK, N. Y.

Name	*School of Graduation*	*Year*	*Address*
Clothier, W. J. K.	Toronto	1928	717 N. E. Avenue, Waukesha
Crosley, A. P., Jr.	Pennsylvania	1945	2500 Overlook Terrace, Madison
Curtis, J. L.	George Washington	1949	145 Elk Place, New Orleans, La.
Evans, A. S.	Buffalo	1943	Wisconsin General Hospital, Madison
Gallagher, W. B.	Minnesota	1948	1927 W. Kilbourn, Milwaukee
Ghormley, K. O.	Harvard	1946	2149 Mississippi Street, La Crosse
Gillies, W. G.	Louisiana	1949	Hazel Green
Hammond, D. F.	Louisiana	1949	Route 12, Box 444, Dayton, Ohio
Hulme, A. W.	Washington	1948	345 W. Grand Avenue, Wisconsin Rapids
Ivie, D. C.	Iowa	1949	3614 Cross Street, Madison
Lovelace, D. D.	Tufts	1934	Mountain Lake, Minn.
McClung, J. L.	Michigan	1945	3102 Strawberry Lane, Port Huron, Mich.
McNearney, J. A.	St. Louis	1939	St. Mary's Hill Hospital, Milwaukee
Meade, R. C.	Minnesota	1951	V. A. Hospital, Wood
Myers, S. C.	Western Reserve	1949	Box 277, Monticello, Miss.
Nordin, P. F.	Marquette	1947	Milwaukee County Hospital, Milwaukee
Obuszkewycz, L. S.	Catholic, Louvai, Poland	1940	4909 Larkins Street, Detroit, Mich.
Olson, M. J.	Wisconsin	1947	South Wayne
Pace, A. J.	Loyola	1929	1843 N. Natoma, Chicago, Ill.
Palitz, S. F.	New York	1945	5020 N. Lake Drive, Milwaukee
Petersen, J. J. G.	Tufts	1948	1200 Center Street, Racine
Rasmus, R. B.	Iowa	1948	2206 Johnson Street, La Crosse
Rosenberg, S. J.	Marquette	1944	1600 Randalia Drive, Fort Wayne, Ind.
Ryan, D. J.	Syracuse	1947	Rapid City Air Force Base, Rapid City, S. D.
Swann, R. O.	New York	1947	1328 Cherry Street, Wausau
Walker, D. L.	California	1945	521 Togstad Glen, Madison
Webster, Jean H.	Wisconsin	1929	University of Wisconsin, Madison
Williams, R. R.	Louisville	1946	St. Mary's Hospital, Wausau
Wunsch, C. A.	Illinois	1946	704 S. Van Buren, Green Bay

MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have graduated from medical school within the past ten years and are residing in the state of Wisconsin or are in the Armed Forces at the time the essay is submitted. Physicians who graduated from medical school more than ten years ago may submit essays if deduction of their period of service in the Armed Forces will bring them within the above-mentioned ten year period after graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial Contest for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, though not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be double spaced and submitted in triplicate to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

535 North Dearborn Street, Chicago 10, Illinois

ICAN MEDICAL ASSOCIATION news notes

JULY 1953

AMA news written especially for use in state medical journals

NBC–TV to Carry Series of 5-Minute Health Spots

"M.D."—a new television series produced by F. William Hart in cooperation with the American Medical Association will be aired beginning Monday, June 1, over all 45 NBC–TV network stations. This 26-week series will be presented as a public service by the National Broadcasting Company and E. R. Squibb & Sons. Featuring valuable health tips from "your family physician and his county medical society," the program will be presented as a portion of the Dave Garroway "Today" show every Monday morning.

As the cooperating agency in the production of the series, the AMA clears all scripts, reviews the films, and passes on all national sponsors. Whenever the programs are televised locally, the county medical society will have the right to approve local sponsors.

PR Institute Set for September

Outstanding postgraduate courses in medical public relations will be offered at the AMA's second Public Relations Institute for all state and county PR personnel. "Classes" will convene September 2 and 3 at Chicago's Drake Hotel.

Topics such as medical forums presented by medical societies in cooperation with local newspapers and tips on how to conduct successful public relations programs on limited budgets will be discussed by authorities in the field. In addition, emphasis will be placed on the use of television as a PR medium. Specially filmed shows available for use by local medical societies will be given a preview at the Institute.

Designed primarily for lay public relations employees of state and county medical societies, the program will include both talks by PR experts and bull-sessions to give each registrant a chance to solve his special local problems.

AMA Transcriptions Feature Healthy Summer Fun

Everyday health problems facing the average American family during the summer months form the basis of a new series of radio transcriptions to be released in July by the Bureau of Health Education. The 13-program series, "June, July and August," dramatizes the adventures of the typical Holloway family and their friends . . . on the farm, in the woods, at the beach. With Ralph Camargo as host, the dramatic presentations are followed by discussions of summer health problems by W. W. Bauer, M. D., Bureau director. Subjects include: Poison Oak and Ivy; Water Safety; Highway Safety; Sun and Sorrow; Hay Fever; Summer Insects; High Powered Vacation; Baby Health; Summer Eating; Keep Cool; Farm Hazards; Air Conditioning; and Summer Clothing. The series is available on loan to local medical societies through the Bureau.

AMA Publishes Health Insurance Booklet

The seventh annual revision of the health insurance brochure published by the Council on Medical Service and its Committee on Prepayment Medical and Hospital Service now is available to physicians and allied groups. In this booklet—"Voluntary Prepayment Medical Benefit Plans"—each plan is described by summary of benefits, enrollment at the end of 1952, and other pertinent data. Separate sections list plans by type of sponsorship. Also identified are plans which have been granted the Council's seal of acceptance. One section is devoted to Canadian plans which have been organized or approved by the provincial branches of the Canadian Medical Association. In addition, other types of programs are described to give examples of voluntary methods of insuring some of the costs incident to health care. Single copies are available, without charge, from the Council.

New Booklet for All AMA Members

How the AMA may serve you . . . as one of its members . . . is the theme of a new pamphlet which the American Medical Association will publish this summer. Designed to acquaint members with the AMA's many activities and services, "It's Your AMA" will be mailed to every member, and, thereafter, will be sent to each new member of the Association.

New Platters—AMA Contributions to Better Health

Common health problems and how the American Medical Association has helped to solve them form the basis of a new series of radio transcriptions to be relased May 15. The 13 program series—"Yours for Health"—shows how the work of various AMA councils and committees has contributed to better health for the American people. Subjects included in the series prepared by the Bureau of Health Education: (1) How Do We Know? Facts and Statistics, (2) Food and Nutrition, (3) The Part Played by Drugs, (4) Impaired Hearing and Hearing Aids, (5) Training Good Doctors, (6) You and Your Hospital, (7) It's the Law, (8) Defense Against Poisons, (9) Safe Cosmetics, (10) Meeting Medical Costs, (11) Health and the Aged, (12) Driving Out the Quacks, and (13) Mental Health.

Society Proceedings

Ashland–Bayfield–Iron

The Menard Hotel in Ashland was the site of the May 20 meeting of the Ashland–Bayfield–Iron County Medical Society. The highlight of the scientific portion of the program was a talk on back conditions by *Dr. Robert E. Burns*, professor of orthopedic surgery at the University of Wisconsin Medical School. The doctor showed movies to supplement his talk.

Manitowoc

Dr. Walter H. Scherping was elected president of the Manitowoc County Medical Society at the annual dinner meeting held on April 30 at Wellhoefer's Grill in Manitowoc. Other officers elected include *Dr. Charles E. Wall*, vice president; *Dr. Daniel M. Pick*, secretary-treasurer; *Dr. William A. Rauch*, censor; *Dr. E. C. Cary*, Reedsville, delegate; *Dr. R. G. Strong*, alternate; *Dr. John D. Lynch*, public relations; and *Dr. Wallace S. Marshall*, Two Rivers, public relations. Except where otherwise noted, all the officers are from Manitowoc.

Outagamie

Dr. James M. Sullivan, Milwaukee, was guest speaker at the May 21 meeting of the Outagamie County Medical Society. Meeting with members of the society at the Appleton Elks Club, Doctor Sullivan chose "Diseases of the Venous System" as the subject of his talk.

Price–Taylor

The Price–Taylor County Medical Society held its May 23 meeting at the Phillips High School. *Dr. L. W. Moody*, director of the Pureair Sanatorium at Bayfield, presented a paper on "The Value of X-Ray in the Diagnosis of Chest Diseases" during the scientific portion of the meeting.

The annual election of officers resulted in the following slate of physicians to serve during 1953–1954:

President—*J. L. Rens*, Phillips
Vice President—*W. E. Niebauer*, Phillips
Secretary—*James J. Leahy*, Park Falls

Richland

Ten members of the Richland County Medical Society heard an address by *Dr. H. Kent Tenney*, Madison, at their May meeting, which was held at *Dr. W. C. Edward's* cottage near Riverview. Doctor Tenney, who is president-elect of the State Society, chose "Prevention of Psychiatric Problems in Children" as the title of his talk.

Waupaca

F. W. REICHARDT, M. D.

Meeting at the Elwood Hotel in New London, members of the Waupaca County Medical Society discussed the county pension plan, legislation concerning chiropractors, and the Woman's Auxiliary during the business portion of the program. For the scientific portion *Dr. F. W. Reichardt*, Stevens Point, was the featured speaker. The doctor, who is associated with the Rice Clinic, discussed "The Treatment of Fractured Hips."

Wisconsin Heart Association

H. H. SHAPIRO, M. D.

Dr. Herman H. Shapiro, a Madison heart specialist, was elected president of the Wisconsin Heart Association at its annual meeting on May 23 in Milwaukee. *Dr. Howard L. Correll*, Milwaukee, was named president-elect at the meeting.

Doctor Shapiro is chief of the cardiovascular section of the University of Wisconsin Medical School and an associate professor of medicine. Doctor Correll has taught medicine at the universities of Wisconsin and Iowa and is presently a professor of medicine at Marquette University.

Two physicians, *Dr. R. F. Wagner*, Oshkosh, and *Dr. R. L. Gilbert*, La Crosse, were elected for three year terms on the board of directors. Physicians who were reappointed to the board include *Drs. S. F. Morgan* and *G. C. Owen*, both of Milwaukee; *Drs. C. W. Crumpton* and *R. N. Allin*, both of Madison; *Dr. G. R. Barry*, Monroe; and *Dr. J. B. MacLaren*, Appleton.

Wisconsin Society of Obstetrics and Gynecology

G. H. STEVENS, M. D.

The annual spring meeting of the Wisconsin Society of Obstetrics and Gynecology was held at the Fond du Lac Elks Club on May 2. New officers include *Dr. G. H. Stevens*, Wausau, president; *Dr. G. S. Kilkenny*, Milwaukee, vice president; and *Dr. D. D. Willson*, Fond du Lac, secretary-treasurer.

The morning program consisted of discussions by *Dr. Lee B. Stevenson*, Madison, "Adenocarcinoma of the Fallopian Tube"; *Dr. Dean D. Willson*, Fond du Lac, "Cesarean Section, Ten Year Survey at St. Agnes Hospital, Fond du Lac"; *Dr. Abraham Marck*, Milwaukee, "Routine Roentgen Pelvimetry in the Primigravida"; *Dr. N. L. Low*, Racine, "Birth Injuries"; and *Dr. Richard T. Flynn*, Milwaukee, "Premature Separation of the Placenta."

After luncheon Dr. Irwin H. Kaiser of the department of obstetrics and gynecology at the University of Minnesota Medical School addressed the group. His subject was "Exchange of Respiratory Gases between the Mother and the Fetus."

Wisconsin State Radiological Society

R. L. TROUP, M. D.

Members of the Wisconsin State Radiological Society held a meeting on May 23 at the Wagon Wheel Inn near Beloit. The morning and early afternoon meetings were devoted to the presentation of scientific papers. Among the physicians who participated in the program were *Drs. I. I. Cowan, J. E. Habbe*, and *R. W. Byrne*, all of Milwaukee; and *Drs. E. A. Pohle, O. A. Stiennon, F. F. Golden, L. W. Paul*, and *E. H. Betlach*, all of Madison.

At the business meeting held late in the afternoon the following officers were elected to serve for the coming year: *R. L. Troup, M. D.*, Green Bay, president; *I. I. Cowan, M. D.*, Milwaukee, president-elect; and *W. W. Moir, M. D.*, Sheboygan, secretary-treasurer.

Prescription Perfect

RED LABEL • BLACK LABEL

Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.

Born 1820 . . . still going strong

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

News Items and Personals

Fennimore Holds "Dr. Bailey Day"

Fennimore took an afternoon off recently to pay tribute to a physician who has served the community for 50 years. He is *Dr. Mark A. Bailey*, and on June 4 a half-holiday was declared to celebrate "Dr. Bailey Day." Sponsored by the American Legion post and its Auxiliary, the Kiwanis Club, and the Fennimore City Council, the celebration included a parade, a program of speeches and tributes to Doctor Bailey in the Memorial Auditorium, and a social hour. Special guests were some of the 2,000 babies that Doctor Bailey has delivered in Fennimore and the surrounding area.

Doctor Bailey started his practice in association with his father, the late Dr. A. B. Bailey, in May of 1903, the date of his graduation from Bennett Medical College in Chicago (now Loyola University School of Medicine). The senior Bailey died in 1922. Between them, father and son have a record of over 100 years of practice in Fennimore.

In addition to his role as a country doctor, Doctor Bailey has served in a number of civic capacities, as mayor, as health officer, and in community organizations. He was a captain in World War I, returning to civilian life just in time to assist his father in the severe flu epidemic of 1918. He refers to that year as the most difficult in his half century of practice.

Doctor Hulme Moves to Wisconsin

Dr. Andrew W. Hulme, formerly of Hibbing, Minn., recently established a practice in association with *Drs. R. E. Garrison* and *G. H. Handy* of Wisconsin Rapids. A 1948 graduate of the Washington University School of Medicine, St. Louis, Doctor Hulme served his internship and a year of training in surgery and obstetrics at Henry Ford Hospital, Detroit, Mich. He plans to do general practice, with emphasis on obstetrics.

Grantsburg Is Doctorless

The departure of two physicians, one for military duty and one to accept a position in Minnesota, has left the community of Grantsburg temporarily without a doctor. On April 20 *Dr. R. L. Hartzell* reported to Gunter Air Force Base, Montgomery, Ala., for a two-year hitch in the air force. At the completion of his military service, he plans to re-open his Grantsburg office.

About the middle of May *Dr. C. O. Lindberg*, Grantsburg's only other doctor, accepted a position in Sandstone, Minn.

Doctor Phaneuf Reaches 84

About two hundred relatives and friends of Dr. Stanislaus J. Phaneuf gathered in St. Anne's Hall, Somerset, on April 30 to honor the doctor on his 84th birthday. Doctor Phaneuf has a record of 58 years of service to the Somerset community.

Doctor Bergwall Accepts New Job

After 22 years of practice in and around Hartland, *Dr. R. P. Bergwall* has taken a post at the Milwaukee County Hospital. He will serve as physician to the mentally deficient.

Doctor Liebenow Reports for Duty

Beginning a two-year assignment in the Army Medical Corps, *Dr. R. R. Liebenow* of Lake Mills reported on May 26 to Fort Sam Houston, San Antonio, Texas. He holds the rank of first lieutenant.

The doctor's wife and daughter plan to remain in Lake Mills.

West Bend Clinic to Move

A new home for the West Bend Clinic, providing better parking facilities and a ground-floor entrance for patients, has been purchased by *Drs. S. J. and R. H. Driessel*, the father-son team who operate the clinic. Now situated on the second floor of the Peterson Building, North Main Street, the clinic will move to its new location in the former Dave Present home on South Sixth Avenue as soon as remodeling has been completed.

Dr. W. B. Helme Takes Mayo Job

A four-year fellowship in neurology at the Mayo Clinic has called *Dr. William B. Helme* from Burlington, where he started his medical practice in September 1952. Doctor Helme reported at Mayo on July 1.

Doctor Gloss Leaves Appleton

An office for the general practice of medicine, surgery, and obstetrics has been opened in Little Chute by *Dr. Albert J. Gloss*. Doctor Gloss formerly lived in Appleton.

Heisel Is Sanatorium Head

Announcement has been made of the selection of *Dr. John G. Heisel* of Superior as head physician at the Douglas County Home and Sanatorium. Doctor Heisel is replacing *Dr. Herbert B. Christianson*, also of Superior, who has resigned the post to accept a position at the Mayo Clinic.

SHOREWOOD
HOSPITAL • SANITARIUM
2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

Doctor Fostvedt Attends Biology Meeting

During the second week of April *Dr. G. A. Fostvedt,* Barron, attended a three-day meeting of the American Federation of Societies for Biology at the Congress Hotel in Chicago. A member of the American Men of Science, Doctor Fostvedt was present at the special sessions on new drug developments.

Schoen Enters Military Service

Dr. Roland F. Schoen, a practicing physician and surgeon in Beaver Dam for the past 14 years, has reported for duty in the Army Medical Corps at the Brooke Army Medical Center, Fort Sam Houston, San Antonio, Texas. Classified as a general surgeon, Doctor Schoen volunteered for two years' service. He has been commissioned as a major.

A native of Beaver Dam, Doctor Schoen is a son of the late Dr. R. E. Schoen. He holds a degree from Northwestern University Medical School.

Doctor Poser Named Health Officer

At a recent meeting of the Common Council of Columbus, *Dr. J. F. Poser* was appointed City Health Officer. He is replacing *Dr. C. F. Cheli.* A graduate of the University of Wisconsin Medical School, Doctor Poser is a fellow of the International College of Surgeons.

Doctor Bear Honored at Dinner

At the annual dinner for medical men given by the sisters of St. Clare Hospital in Monroe on May 18, *Dr. W. G. Bear* was commended for his 50 years of service to the Monroe community. Doctor Bear came to Monroe in 1903 as an associate of the late Dr. N. A. Loofbourow.

A 1902 graduate of Rush Medical College in Chicago, Doctor Bear served his internship at Presbyterian Hospital there. In his early years in Monroe, he cared for a third of the people in Green County, traveling from patient to patient by horse and buggy. It has been estimated that he has delivered more than 4,000 babies in the area.

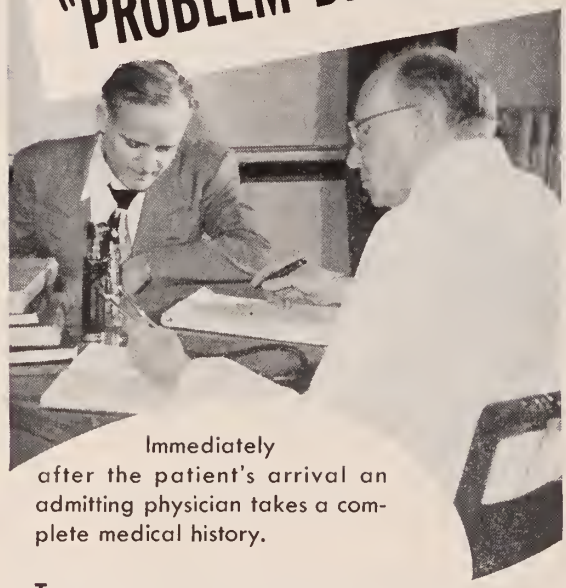
One of the founders of the Monroe Clinic, Doctor Bear was also active in developing the Loofbourow Hospital. He formerly served as chief of staff of St. Clare Hospital.

An editorial in the Monroe *Times* published after the dinner in Doctor Bear's honor reads, in part:

"Dr. Bear received the accolade he probably cherished the most at this week's annual dinner for doctors at the hospital. It might have been an all-community affair, except for the fact that no hall exists in Monroe large enough to include all who would have liked to share in the salute.

"So, we'll just join those thousands in wishing him many more happy years of helping see to it that Monroe stays on top in health, too."

Individualized Care for the "PROBLEM DRINKER"



Immediately after the patient's arrival an admitting physician takes a complete medical history.

Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

McCullough Released from Service

After more than a year with the medical field service of the United States Army in Germany, *Dr. John C. McCullough* has resumed his practice at the Devine Clinic in Fond du Lac.

A member of the reserves, Doctor McCullough entered the army as a captain on April 21, 1951, and attended basic medical field service school at Fort Sam Houston, Texas. After an assignment at Percy Jones Hospital, Battle Creek, Mich., he went overseas with a medical corps unit in February 1952.

Clintonville Psychiatrist Discusses Mental Health

"One out of every five" people in the nation will eventually need medical assistance for mental disturbances, *Dr. J. J. Mulvaney* told the Junior Woman's Club of Clintonville at its April 20 meeting. A practicing psychiatrist in Clintonville, Doctor Mulvaney discussed the various treatments used for mental disorders.

Dr. Donald K. Buffmire Joins Bolton–Mielke Clinic

Drs. E. L. Bolton and *E. F. Mielke* of the Bolton–Mielke Clinic in Appleton have been joined in practice by *Dr. Donald K. Buffmire*, who will specialize in internal medicine. Recently discharged from the Army Medical Corps, Doctor Buffmire is a graduate of Northwestern University Medical School and served his internship at the Evanston (Ill.) Hospital. Before entering the service he completed a three-year fellowship in internal medicine at the Mayo Clinic.

Dr. L. V. Kempton Enters Service

Dr. Leo V. Kempton, an associate of *Dr. Leif Erickson* at the Burlington Clinic, reported May 4 at the Gunter Air Base in Montgomery, Ala. After completing his two-year hitch, he plans to return to Burlington.

Doctor Pawsat on PTA Panel

Dr. E. H. Pawsat, Fond du Lac pediatrician, was one of the participants in a panel discussion at the annual Wisconsin Congress of the Parent-Teachers Association in La Crosse April 21–23. Topic of the discussion was "Does the School Meet Individual Differences?"

Russo Speaks to Outagamie Group

Dr. John G. Russo of Kaukauna, director of the Riverview Sanitarium, spoke to members of the Outagamie County Health Council at its April 30 meeting. His talk was part of a survey for the mobilization of all resources in Outagamie County to promote and protect the health of the people.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. T. G. Allin Starts Practice in Plain

Dr. Thomas G. Allin of Madison has taken over the practice of *Dr. Yoshio Handa* at Plain. Doctor Handa, who is leaving to take two years of further study at Hines General Hospital in Illinois, may return to Plain later to practice with Doctor Allin.

A graduate of the University of Wisconsin Medical School and a veteran of the war in Korea, Doctor Allin has practiced with the Dean Clinic in Madison for the past year.

U. W. Holds Program for Medical Alumni

Some 300 of the University of Wisconsin's Medical School graduates returned on May 14 to attend the 1953 Alumni Day activities. The morning program featured the traditional "Grand Rounds" of Wisconsin General Hospital, with leading medical school faculty members reviewing the latest advances in their special fields.

During the afternoon the Class of 1933 presented a scientific program. Members of the class presenting reports included Dr. Horace R. Getz, medical director, the Charles Cook Hastings Home, Altadena, Calif., "Nutrition and Tuberculosis"; *Dr. A. R. Curreri*, Madison, "Dextran and Shock"; Dr. Edwin S. Sinaiko, Chicago, "Intestinal Anastomosis"; Dr. H. P. Rusch, Madison, "Advances in Cancer Research"; Dr. Stuart C. Cullen, chairman of the division of anesthesiology, State University of Iowa, "Xenon as an Anesthetic Agent"; and Dr. Henry W. Brosin, director of the Western Psychiatric Institute, University of Pittsburgh, "Dynamics of Obesity and Anorexia Nervosa."

Doctor Sweeney Reports for Duty

Dr. Thomas C. Sweeney of Beloit has reported for duty at the Brooke Army Medical Training Center at Fort Sam Houston, San Antonio, Texas. The doctor was commissioned as a captain and will spend about eight weeks at Brooke before receiving his permanent assignment.

Doctor Sweeney opened his practice in Beloit in January 1944 after completing his internship at Milwaukee County Hospital. For the past five years he served as physician for the Beloit school system.

Doctor Reese to Preside over Atlantic City Meeting

Dr. Hans H. Reese, professor of neuropsychiatry at the University of Wisconsin, gave his presidential address at the annual meeting of the American Neurological Association, held in Atlantic City, June 15–17.

The doctor also attended the New York meeting of the AMA, where he was reappointed delegate to the Section on Nervous and Mental Diseases of the

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

Western Electric HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

HER BEST INVESTMENT

WE asked a retired lady to tell us about the best investment she ever made. She replied, "That's easy. See that second box in the top row left. That is mine. I live at this hotel. On the first or second day of every month, my retirement check from my insurance company arrives. I can spend it all because another will be there every month for life. That is real satisfaction and comfort to me."

Fill out and mail to The Wisconsin Life Insurance Company, 30 West Mifflin Street, Madison, Wisconsin, the coupon below for detailed information without obligation.

Please explain how I can assure a monthly retirement income check for life to myself.

Name _____

Date of Birth _____

Address _____

City _____ State _____

Association. Two other honors were recently awarded him when the Mexican Surgical and Neuro-Surgical Society made him an honorary member and the German Neurological and Neurosurgical Association appointed him a corresponding member.

Doctor Angevine Honored by Pathologists

Dr. D. Murray Angevine, chairman of the department of pathology of the University of Wisconsin, was recently honored by his election to the office of president of the American Society for Experimental Pathology. In addition the doctor has been appointed by the American Board of Pathology to serve as consultant for hospital residency approval.

Doctor Angevine attended the annual meeting of the Federation of Biological Sciences held in Chicago in April, where he presided at a session on infectious diseases. On April 15 he presented a talk entitled "The Pathology of Rheumatic Disease" before the Upper Michigan Peninsula and Wisconsin Medical Society.

Dane

The decline of civil liberties in the United States and regimentation of American political opinion to a level of conformity and orthodoxy were discussed by William T. Evjue, editor and publisher of *The Capital Times*, at the April 14 meeting of the Dane County Medical Society. Following Mr. Evjue's talk at the Madison Club, he and some of the attending physicians engaged in a lively debate during a question-and-answer period on socialized medicine.

Among the physicians participating in the question-and-answer period were *Drs. C. O. Vingom, Stuart A. McCormick, D. L. Williams*, and *W. T. Lindsay*, all of Madison; and *M. T. Morrison*, Mt. Horeb.

On May 12, members of the Society met at the Madison Club, Madison, for a final meeting prior to the summer recess. Dr. Robert P. Glover, professor of surgery at Hahnemann Hospital, Philadelphia, Pennsylvania, addressed the group on "Surgery of Mitral and Aortic Stenosis."

Doctor Glover, whose appearance was made possible through the cooperation of the Wisconsin Heart Association, described the indications, technic, and results of a series of nearly 500 cases over the past five years. Emphasis was placed on early mitral stenosis in cases without enlargement of the left ventricle. Slides were shown in illustration, and a short movie of Doctor Glover's surgery concluded the presentation.

A short business discussion included a report on civil defense preparations and a summer camping program for diabetic youngsters.

Cerebral Palsy Clinic

More than 250 patients have been seen by the Cerebral Palsy Clinic in Milwaukee since it was organized in 1950, *Dr. Raymond C. Waisman*, medical director, told the Cerebral Palsy League of Mil-

waukee at a meeting on May 27. Doctor Waisman paid tribute to the parents' group for providing the impetus for the clinic, which operates under the supervision of the Medical Society of Milwaukee County.

The Kiwanis Foundation will provide a new building for the rapidly growing clinic. Present plans are for the building to be located on North 19th Street, just south of the present site.

Milwaukeean to Head National Group

J. D. STEELE, M. D.

Dr. John D. Steele, Milwaukee chest surgeon, was named president-elect of the American Trudeau Society at its annual meeting in Los Angeles. Doctor Steele currently is secretary-treasurer of the society and has also been re-elected to the executive committee of the board of directors of the National Tuberculosis Association.

Director of surgery at Muirdale Sanatorium, Doctor Steele is also an assistant clinical professor of medicine at Marquette University School of Medicine.

Milwaukee

Prizes in the annual Gramling Memorial Essay Contest of the Medical Society of Milwaukee County were presented at the May 14 meeting of the society. First prize of $100 was awarded to *Dr. Sidney K. Wynn* for a paper on "Bone Flap Technique in Cleft Palate Surgery." Co-author of the paper was *Dr. V. B. Hyslop,* who was not eligible for the award because he has been out of medical school for more than 10 years, excluding time spent in military service.

The second prize of $50 went to *Dr. Thomas J. Beno,* now serving in Korea, for a paper entitled, "Spontaneous Contralateral Pneumothorax Complicating Thoracic Surgical Procedures." His co-author was *Dr. Wilson Weisel,* who was not eligible. Dr. Robert Swart accepted the award for Doctor Beno.

Dr. Alfred Uihlein, a consultant and neurosurgeon at the Mayo Clinic, was the guest speaker at this meeting. He discussed the treatment of head injuries.

When you read the advertising pages of the *Journal,* remember this: all ads are carefully screened—our standards are of the highest. Our advertisers seek your patronage and your response encourages their continued use of our publication. When you send inquiries, tell them that you read their advertisement in *The Wisconsin Medical Journal.*

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting August 3, September 14, September 28.
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting August 3.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting August 17.
Basic Principles in General Surgery, Two Weeks, starting September 21.
Surgery of Colon & Rectum, One Week, starting September 21.
General Surgery, One Week, starting October 5.
General Surgery, Two Weeks, starting October 12.
Thoracic Surgery, One Week, starting October 12.
Esophageal Surgery, One Week, starting October 19.
Breast & Thyroid Surgery, One Week, starting October 26.
Gallbladder Surgery, Ten Hours, starting October 26.
Fractures & Traumatic Surgery, Two Weeks, starting October 26.
GYNECOLOGY—Intensive Course, Two Weeks, starting September 21.
Vaginal Approach to Pelvic Surgery, One Week, starting August 31.
OBSTETRICS—Intensive Course, Two Weeks, starting October 5.
MEDICINE—Intensive General Course, Two Weeks, starting September 28.
Electrocardiography & Heart Disease, Two Weeks, starting October 12.
Allergy, One Month and Six Months, by appointment.
CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting September 28.

Teaching Faculty—Attending Staff of Cook County Hospital
Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clyboum St. Milwaukee 3, Wisconsin

To Serve Your Complete Prosthetic & Orthopedic Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

The Knox Gelatine Diet and the Convalescent Child

Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Loss of nitrogen cannot be prevented; however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect.[3]

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[1] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

Knox Gelatine is easy to digest, while its supplementary dietary nitrogen will furnish protein without other substances, especially salts of potassium which are retained during convalescence; without excess fat and carbohydrate, which are not needed especially; and without a food volume which may interfere with intake.

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.

AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES

Write today for your free copy "Feeding the Sick and Convalescent." Knox Gelatine, Johnstown, N. Y.; Dept. WS

KNOX GELATINE U.S.P. ALL PROTEIN NO SUGAR

SOCIETY RECORDS

New Members

A. W. Hulme, 345 West Grand Avenue, Wisconsin Rapids.

D. J. Baker, 643 Geneva Street, Burlington.

W. H. Hale, 214 North Superior Street, Appleton.

W. G. Gillies, Hazel Green.

W. S. Cusick, Bloomington.

Norman Cameron, 3507 Sunset Drive, Madison.

W. P. L. McBride, Box 275, Route 1, McFarland.

F. J. Flanagan, Hortonville.

Frank Wright, Jr., 103 West College Avenue, Appleton.

J. J. G. Petersen, 1356 Washington Avenue, Racine.

H. J. McLane, 80 Sheboygan Street, Fond du Lac.

Changes in Address

E. H. Federman, Montello, to Moor Hotel, Waukesha.

B. J. Mansheim, Iowa City, Iowa, to 2165 Adams Street, La Crosse.

R. B. Leitschuh, Waukesha, to 1301 Arthur Avenue, Racine.

T. G. Allin, Madison, to Plain.

D. K. Buffmire, Fort Sheridan, Illinois, to 215 West Lawrence, Appleton.

G. P. Nichols, Madison, to 2429 Paseo Road, Colorado Springs, Colorado.

L. G. G. Glasson, Milwaukee, to Jackson Memorial Hospital, Miami, Florida.

R. J. Maginn, Goodman, to Niagara.

W. K. Hoffman, Camp Rucker, Alabama, to 425 East Wisconsin Avenue, Milwaukee.

W. A. Hilger, Madison, to 1744 North 34th Street, Milwaukee.

R. R. Liebenow,* Lake Mills, to 01934141, U.S.A.R., Stu. Det., Med. Field Service School, Brooke AMC, Fort Sam Houston, Texas.

C. H. Schmidt,* Milwaukee, to U.S.A.F., 93rd Medical Group (SAC), Castle Air Force Base, California.

K. P. Grubb,* Great Lakes, Illinois, to 1002 North La Salle Street, Chicago, Illinois.

H. R. Duffy,* Milwaukee, to U. S. Naval Training Station. Pensacola, Florida.

J. R. Evrard,* Great Lakes, Illinois, to EENT Department, Camp Breckenridge, Kentucky.

S. E. Sivertson, La Crosse, to Mayo Clinic, Rochester, Minnesota.

L. S. Kellogg,* Montgomery, Alabama, to Randolph Field Flight Surgeon's School, San Antonio, Texas.

H. J. Kanin,* Milwaukee, to 273 Menlo Boulevard, San Antonio, Texas.

J. P. Miller,* Milwaukee, to A02260150 Base Hospital, Hq. 2750th Medical Group, AMC, Wright-Paterson Air Force Base, Ohio.

---

* Military Service.

M. L. Weber,* Milwaukee, to Lockhaven Apartment 206–207, 3037 Market Street, Seattle, Washington.

J. P. Semmens,* Waupun, to U.S.N.R., Sta. Res. Quarters "G," U. S. Naval Magazine, Port Chicago, California.

J. R. Allen, Madison, to Route 2, Waunakee.

*Military Service.

DEATHS

Dr. George R. Love, 56, Oconomowoc physician and well-known golfer, died at his home on May 26, 1953. He was born in Moran, Kansas, on January 16, 1897.

Doctor Love was a graduate of the University of Arkansas and the Hahnemann Medical College in Chicago and received a master's degree from the University of Illinois before coming to Oconomowoc in 1922. For 30 years he was head and principal owner of the Summit Hospital.

In 1942 Doctor Love organized the Wisconsin Medical Golf Association and served as its president for three years. He was senior medal and match play champion in Wisconsin and was prominent nationally in senior golf.

Doctor Love was a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his wife, Elaine, and his mother, Mrs. George M. Love of Rogers, Arkansas.

Dr. Samuel M. Vachitinsky, 59, died suddenly on January 17, 1953. He had been engaged in general practice in Milwaukee for over 30 years.

Doctor Vachitinsky was born in Russia on March 22, 1893. He was a 1918 graduate of the Marquette University School of Medicine and served his internship at Milwaukee County General Hospital.

Dr. Erick von Buddenbrock, 71, Racine physician and surgeon, died suddenly at his home on May 20, 1953. He was born in Del Norte, Colorado, on April 1, 1882.

At the time of his death Doctor von Buddenbrock was a member of the active staff of St. Luke's Hospital and an associate staff member of St. Mary's Hospital. He had formerly served as chief of staff at St. Luke's.

Doctor von Buddenbrock attended Sacred Heart (now Regina) College in Denver and received his medical education at the University of Pennsylvania School of Medicine, graduating in 1905. After practicing in Denver for a few years, Doctor von Buddenbrock was brought to Racine by the Horlick family as company and personal physician.

A member of county, state, and national medical societies, Doctor von Buddenbrock served as president of the Racine County Medical Society in 1939. He was a member of the American College of Surgeons.

There are no immediate survivors.

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director

Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.

Wendell T. Wingett, M. D.

Dr. Stuart H. Perrin, Superior physician, died after a brief illness at his summer home on Lake Nebagamon on May 16, 1953. He was 50 years old.

A native of Star Prairie, Doctor Perrin was born on July 8, 1902, the son of the late Dr. Harry Perrin. He was a 1928 graduate of the University of Wisconsin Medical School and served his internship at St. Francis Hospital in La Crosse. Since 1934 he had been engaged in the practice of general surgery and orthopedics in Superior.

Doctor Perrin was a member of the Douglas County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Esther; a son, James; and two daughters, Esther and Susan, all of Superior.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 Milwaukee, Wis.

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL

(The Pioneer Post-Graduate Medical Institution in America, Organized 1881)

DERMATOLOGY AND SYPHILOLOGY

A three year course fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also five-day seminars in Dermatopathology, for specialists and for general practitioners.

EYE, EAR, NOSE AND THROAT

A combined full time course covering an academic year (9 months) It consists of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver); clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients preoperatively and follow-up post operatively in the wards and clinics; attendance at departmental and general conferences. Also refresher courses (3 months).

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS

	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

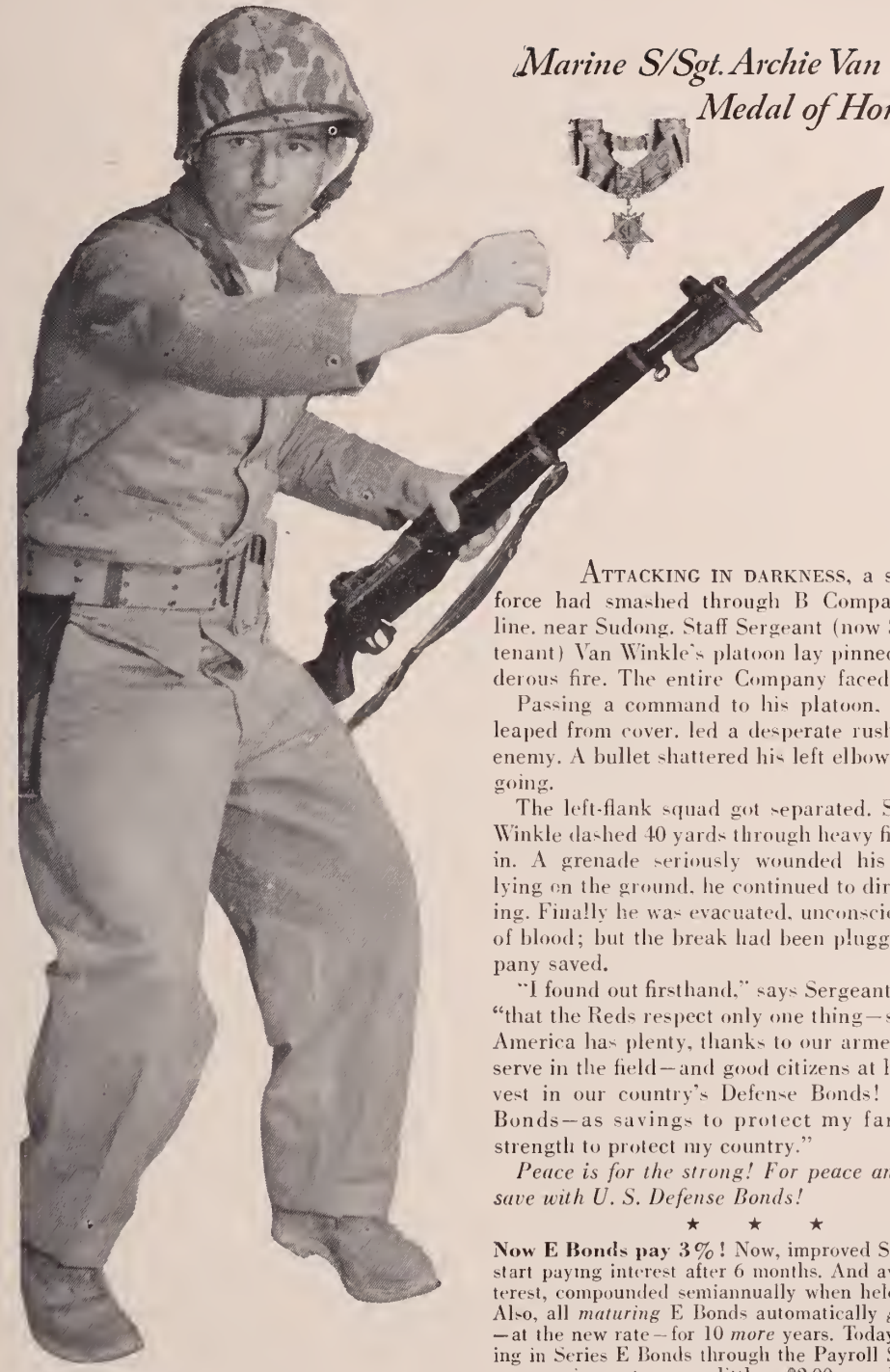
$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

Prescribe Journal-advertised products and you prescribe the best.



Marine S/Sgt. Archie Van Winkle
Medal of Honor

ATTACKING IN DARKNESS, a superior Red force had smashed through B Company's defense line, near Sudong. Staff Sergeant (now Second Lieutenant) Van Winkle's platoon lay pinned under murderous fire. The entire Company faced destruction.

Passing a command to his platoon, the sergeant leaped from cover, led a desperate rush against the enemy. A bullet shattered his left elbow, but he kept going.

The left-flank squad got separated. Sergeant Van Winkle dashed 40 yards through heavy fire to bring it in. A grenade seriously wounded his chest. Still, lying on the ground, he continued to direct the fighting. Finally he was evacuated, unconscious from loss of blood; but the break had been plugged, the Company saved.

"I found out firsthand," says Sergeant Van Winkle, "that the Reds respect only one thing—strength. But America has plenty, thanks to our armed forces who serve in the field—and good citizens at home who invest in our country's Defense Bonds! I believe in Bonds—as savings to protect my family and as strength to protect my country."

Peace is for the strong! For peace and prosperity save with U. S. Defense Bonds!

★ ★ ★

Now E Bonds pay 3%! Now, improved Series E Bonds start paying interest after 6 months. And average 3% interest, compounded semiannually when held to maturity. Also, all *maturing* E Bonds automatically *go on* earning—at the new rate—for 10 *more* years. Today, start investing in Series E Bonds through the Payroll Savings Plan; you can sign up to save as little as $2.00 a payday if you wish.

The U. S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Medical Clinics of North America. Los Angeles Number. Philadelphia and London, W. B. Saunders Company, 1952.

The articles in this volume range, as Doctor Starr states in his forward, from the philosophical, the theoretical, to the practical, and all are of great interest. The practical in the articles pertaining to circulation, for example, correlates physiologic application to clinical material, emphasizing the importance of procedures such as catheterization.

The other subjects covered vary in scope and interest. There are papers on hypertension, coronary disease, hemorrhage disorders, thyroid disease, and magnesium metabolism, to name a few. Characteristic of the rapid advances is the fact that in a book as recent as this the portion on drug usages for hypertension does not name the methonium compounds. Of interest are the implications in the paper on "The Significance of the Birth of a Large Baby."

All in all, these "Clinics" are worthwhile.—H. H. S.

Correlative Neuroanatomy and Functional Neurology. By Joseph J. McDonald, M. S., M. Sc. D., M. D.; professor of surgery, Columbia University; attending surgeon, Presbyterian Hospital, New York; director of the Surgical Service, Francis Delafield Hospital, New York; and Joseph G. Chusid, A. B., M. D., attending neurologist, St. Vincent's Hospital, New York. Sixth Edition. Los Altos, California, University Medical Publishers, 1952. Price $4.00.

The first edition of this outline, which appeared in 1938, consisted of 116 pages of text. The circumstance of publication of this, the sixth edition, in 1952 and its expansion to 257 pages of text attest the efforts of the authors to maintain and enhance its usefulness.

The reviewer concurs in the statements embraced in the preface to the present edition which indicate the changes and additions: "This volume is dedicated to the beginner in neurology. Our aim is to present in the simplest and clearest manner those features of anatomy and physiology of the nervous system which bear upon the problems of clinical neurology. The concise outline format, so favorably received in previous editions, is again employed, supplemented by additional charts, diagrams and illustrations. Appropriate revisions have been made and new material added principally in the fields of aphasia, headache, syncope, and muscle testing. Because the scope of this book has broadened considerably since the time of its original publication as 'Correlative Neuroanatomy,' it is now deemed advisable to change its title to that of 'Correlative Neuroanatomy and Functional Neurology'."

Approximately one-half of the book is devoted to anatomy and physiology of the central and peripheral nervous systems; the remainder treats of principles of neurodiagnosis and disorders of the central nervous system. An excellent index further enhances the value of the work.

Although the outline is dedicated to the beginner in neurology, the facility with which answers to many neurological questions are found indicates its usefulness to others. Any physician, even though remotely interested in neuroanatomy, neurophysiology, and their applications to clinical neurology, should page through it.—F. D. G.

Current Therapy, 1952. Edited by Howard F. Conn, M. D. Philadelphia and London, W. B. Saunders Company, 1952. Price $11.00.

One of the 16 sections in this 849 page book contains a rather useful roster of the drugs which are discussed in the text, along with dosages, conversion factors, and tables for making percentage solutions. Of the other 15 sections one is devoted to a discussion of the therapy of infectious diseases, another to disorders of metabolism and nutrition, one to venereal diseases, another to allergic diseases, and a fifth to treatment of diseases, due to physical and chemical agents (aviation medicine, burns, cold, heat, poisons, snake bites, spider bites).

In the remaining sections specific diseases of the various organ-systems, e. g., urogenital, skin, cardiovascular, are considered. Each section is further

FIRST CENTRAL DISPENSARY
602 First National Bank Bldg.,
Madison 3, Wis.

SHOREWOOD PHARMACY
2611 University Ave.,
Madison 5, Wis.

STANLEY INC., MADISON, WIS.
FOUR STORES
Complete Stocks Of Medical Specialties
Orders Filled Promptly

PHYSICIAN AND HOSPITAL SUPPLIES

RELIABLE PRESCRIPTION SERVICE

STANLEY PHARMACY
Regent and Allen Sts.,
Madison 5, Wis.

STANLEY PHARMACY
402 South Park St.,
Madison 5, Wis.

subdivided into discussions, by one or more authorities in the field, of the methods currently employed in the treatment of a particular disease entity. Diagnosis is not discussed unless it is an integral part of the therapy. In most instances all methods of treatment, both medical and surgical, are rather critically considered, each author expressing his opinion upon the relative merits of the various procedures. Only the barest details are given for surgical methods. The coverage of treatment from the medical standpoint is appreciably more comprehensive and dosages, dosage schedules, routes of administration, etc. are stated. In the reviewer's opinion, *Current Therapy* appears to be a useful reference book for methods of treatment but is somewhat lacking in detail.—F. E. S.

The Science of Health. By Florence L. Meredith, B. Sc., M. D. Second edition. Philadelphia, The Blakiston Company, 1951.

This book is designed for the teaching of hygiene to college students, especially in a short course. The subject matter is divided into five parts. In the first, the introduction, vital statistics are discussed under the heading of "The National Health Situation" and then a brief review of human anatomy is given. The second part deals primarily with physiology and the general effect of exposure to germs, physical agents, and chemical agents. The third part is devoted to the problems of specific diseases, both communicable and non-communicable. In the next section various aspects of mental health are considered; in the final section reproduction, heredity, and parental care are dealt with under the heading, "The Next Generation."

The book is clearly written with good illustrations. Each paragraph introducing a new topic has a title in bold-faced type. Important information is often given in numbered, outline form. These features make for easy reading. The author has included a great deal of information in a palatable and interesting manner.

In her attempt to familiarize the student with specific medical facts and terms, the author sometimes uses illustrations that are too complex and detailed and are not sufficiently explained in the text. For example, a cross section of the human heart is shown without any accompanying explanation. The indoctrination into medical terminology is sometimes carried too far. A brief glossary of commonly used medical terms might help solve this problem.

The shortcomings of this book are those inherent in dealing with so large a subject in so small a volume. There is a tendency to oversimplification, particularly in the author's treatment of the medical aspects of her subject. The book well fulfills the purpose for which it is written, however, and should prove a valuable asset to students and teachers of college hygiene.—A.S.E.

Penicillin Decade. By Lawrence W. Smith, M. D., medical director, Commercial Solvents Corporation; and Ann D. Walker, R. N., former editor, "Trained Nurse and Hospital Review." Washington, D. C., Arundel Press, Inc., 1951. Price $2.50.

How inadequate is the title of this exceptional little monograph! This is especially important, since its content should be of immediate concern to *any* doctor who has prescribed *any* antibiotic for *any* patient. In the subtitle is revealed the actual sum and substance of the text, "1941–1951 Sensitizations and Toxicities." Here is where the importance of the book hits at every practitioner of medicine, for who, in the present day wholesale prescription of the wonder drugs, has not seen or helped produce sensitizations and toxicities?

As is stated in the conclusions, "While the actual *toxicity* of penicillin is almost negligible, its ability to sensitize and to cause serious and even fatal accidents should not be minimized. A grave responsibility rests upon the shoulders of the physician for its wise application to clinical practice." This statement is equally true for every antibiotic now in clinical usage. Yet daily hundreds and thousands of physicians direct the administration of millions of doses of these chemicals without heeding the growing warning in the accumulated literature.

In the review the authors state that they have attempted, entirely objectively, to collect the principal published data relating to any untoward effects of penicillin therapy during the first decade of its clinical use. This brief monograph of 98 pages may be read quite easily in part of an evening. A partial classification of the contents includes: a report of sensitizations and toxicities; urticaria; contact dermatitis; allergic reactions; serum sickness; ana-

COSMETIC *HAY FEVER?*
Prescribe UNSCENTED AR-EX Cosmetics
When perfumes or scented cosmetics cause allergic reactions — prescribe UNSCENTED AR-EX COSMETICS. Clinically tested to meet your high standards. Smart, fashion-right for patient acceptance. All needed beauty aids. *Send for free Formulary*
UNSCENTED
AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

AR-EX
HYPO-ALLERGENIC
Cosmetics
Clinically tested on allergic patients for use by allergic patients

phylaxis; exfoliative dermatitis; ophthalmic reactions; oral reactions; aerosols; beeswax-oil preparations; abortifacients; obstetrical reactions; pediatric problems; renal irritation; central nervous system changes; spinal cord involvement; Jarisch-Herxheimer reaction; miscellaneous reactions; antibodies; blood studies; and bacterial resistance.

A fact emphasized repeatedly by leaders in the field of antibiotic therapy is contained in the conclusions: "It appears advisable to issue a word of caution regarding the indiscriminate use of penicillin or any other antibiotic, for that matter. *Antibiotics are only of value for the treatment of infections due to organisms sensitive to the specific antibiotic being employed.* Not only must the diagnosis be established bacteriologically, but the organisms' sensitivity should be tested in order to determine the most effective antibiotic to employ and the approximate dosage schedule to follow."

The excellent summarization of this monograph should be a warning to the many who have abused the use of this group of drugs in the past.—O.S.O.

The Medical Clinics of North America. Philadelphia Number. Philadelphia and London, W. B. Saunders Company, 1951.

This issue of *The Medical Clinics of North America* bears the title "Symposium on Diagnosis in General Medicine." It consists of some 19 articles which variously review either the general principles of diagnostic procedure or those aspects of study which are of value in a general area of disease, such as heart disease, liver disease, or the like. The material presented is sound, and the presentations are clear and simple, but there is little that is likely to be new to any reasonably well-informed practitioner. The article by Doctors Hollander and Brown on "Diagnosis in the Arthritides" would be well worth while as a stimulant to more careful study of the unfortunates with these diseases, who are so often taken for granted by the overworked physician.

Doctors Squires and Elkinton offer a thesis on the "Clinical Interpretation of Common Abnormalities in the Serum Concentrations of Certain Electrolytes" in terms which would be quite understandable and helpful to those individuals who have left their fundamental chemical instruction far behind them. The time required to read the other articles in this symposium could probably be better spent on other journals.—J.L.S.

The Medical Clinics of North America. Boston Number. Symposium on Specific Methods of Treatment. Philadelphia and London, W. B. Saunders Company, 1951.

Periodic summarization and re-evaluation of available therapeutic resources is a much-needed but time-consuming exercise which many physicians feel is denied them by the press of their daily duties. This issue of the Medical Clinics does the job admirably in a number of specific areas. One or two of the articles are limited in value because they lean so heavily on the device of illustrative case histories, which emphasize a single therapeutic point, but most are of considerable scope. The diseases and problems discussed are ones which present regularly recurring difficulty to the internist. The essayists, drawn from various Boston institutions, are an unusually well-qualified group professionally, and the presentations are clear and specific. Of possible special interest to the vast majority of practitioners who do not have ready access to serum electrolyte determinations is the chapter by Doctors Relman and Schwartz, which emphasizes the clinical approach in the recognition and management of sodium depletion.—J.L.S.

Practical Dermatology. By George M. Lewis, M. D., F. A. C. P.; Professor of Clinical Medicine (Dermatology), Cornell University Medical College; Attending Dermatologist, The New York Hospital; Secretary, The American Board of Dermatology and Syphilology. Philadelphia, W. B. Saunders Company, 1952.

This new book more nearly approaches the type of book that medical students and general practitioners require than any book it has been the privilege of the reviewer to read. Twenty-two chapters are devoted to various common dermatologic disorders and three are devoted to dermatologic therapy and formulary and diagnostic methods.

Where possible the Latin or Greek derivation of the disease name is given. This should make it easier for the student to remember each disease. Important facts about each disease are in heavy type. The photographs are numerous and clear. The treatment of each disease is concisely and clearly explained.

No space is lost in the book through the use of academic dissertations on the theories regarding each disease or on a bibliography. The book does not mention the histologic diagnosis of the diseases covered.

The reviewer without hesitation highly recommends this book.—S.A.M.J.

This is one of a series of advertisements designed to explain the Councils' functions to you.

"Does this product have A. M. A. Council Acceptance?"

The first question many physicians ask the detail man when a new product is presented.

If the detail man can answer "Yes," you know that the composition of the product has been carefully verified, that members of the Council have checked the clinical evidence, the label, the claims and agreed that the product merits your confidence. You can, of course, ask your own questions, and make your own decision about using any product. However, you save yourself a vast amount of time—and gain the benefit of an expert, fact-finding body whose work protects you and your patient. Therefore, why not use Council Acceptance as your guide?

No physician could afford to devote much time and study to every new product. Your Council on Pharmacy and Chemistry renders this service for you, freely. Nowhere else in the world are there groups that perform the functions so ably served by the A. M. A.'s Council on Pharmacy and Chemistry, the Council on Foods and Nutrition and the Council on Physical Medicine and Rehabilitation.

Food and drug companies cooperate with the Councils on a free and voluntary basis. The Councils serve you by giving assurance that the product bearing it has undergone a careful examination. Ask your detail man, "Is this product Council Accepted?"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

ACCEPTED COUNCIL ON PHYSICAL MEDICINE and REHABILITATION AMERICAN MEDICAL ASSOCIATION

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

FOR SALE: 100 ma Mattern x-ray with tilting table, fluoroscopy, spot device, movable table, and remote control. It is 10 years old and in excellent condition. Price $1,400. Owners selling because they are now in a group practice. Address replies to Drs. Koepp and Moss, 1554 Main St., Marinette, Wis.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to the doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE: One 20 ma Fischer x-ray mobile unit, bucky table, and other complete accessories. Excellent condition. Very reasonable. Address replies to Box 487 in care of the Journal.

WANTED, otolaryngologist for Metropolitan EENT group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

WANTED: Used hospital size Bovie Unit. Write: Capitol Hospital, 1971 W. Capitol Dr., Milwaukee, or call Hilltop 5-9100.

PHYSICIAN WANTED as associate in busy, successful practice including surgery in rural, resort, and railroad town of 3,000 in northwest Wisconsin Indianhead region. Fully equipped 13-room modern brick clinic to be completed Sept. 1. Excellent hospital facilities near-by. Local hospital building campaign under way. Salary, percentage, or guaranteed minimum basis initially, with eventual partnership. Address replies to Box 496 in care of the Journal.

FOR SALE: Hellige colorimeter for blood sugars, with glassware but no chemicals, $15. Also cystoscopy 3-cell battery box, $10. Address replies to R. M. Rogers, M. D., Tigerton, Wis.

WANTED: Locum tenens for the month of July or August. Address replies to H. Y. Fredrick, M. D., Westfield, Wis.

CLINIC in Milwaukee needs general practitioner, internist, and pediatrician. Address replies to Box 488 in care of the Journal.

WANTED: Urological table with built-in bucky. Must be relatively new and in good condition. Address replies to Milton Margoles, M. D., 1971 W. Capitol Dr., Milwaukee, Wis.

RADIOLOGIST with ten years' experience, Board certified, desires opportunity for group practice or contact with men interested in forming group. Address replies to Box 489 in care of the Journal.

WANTED: G.P. to work with 2 other G.P.'s in a modern and complete office in south-central Wisconsin. Modern hospital within 15 miles. Ideal hours and working conditions. Address replies to Box 499 in care of the Journal.

EXCELLENT opportunity for general practitioner in a small group located in northeastern Wisconsin. Percentage basis with liberal salary guarantee until established. Permanent position. Address replies to Box 500 in care of the Journal.

FOR SALE: Entire practice and equipment of busy G.P. May lease same office space. A find for anyone starting in Milwaukee. Owner is leaving for residency. Address replies to Box 502 in care of the Journal.

FOR SALE: Home and office combination in city of 1,000 in southern Wisconsin. Requires considerable investment but seller is willing to accept payment over a period of 10 to 15 years. Address replies to Box 490 in care of the Journal.

PHYSICIAN WANTED, preferably with education or experience in addition to the one-year internship, for a general practice which includes considerable surgery. Practice located in a central Wisconsin city of 5,000 with large drawing area and excellent hospital facilities. Arrangements for association open. Address replies to Box 491 in care of the Journal.

FOR SALE: One used GE, F-2, shock proof, wall model x-ray unit especially designed for taking sinus and mastoid x-rays. Every conceivable angle and stereos possible. Complete with modern hand timer, four 8 x 10 cassettes, and accessories, including a 3 gallon composition Buck tank. Address replies to W. G. Meier, M. D., Sheboygan, Wis.

PRACTICE FOR SALE: Completely modern clinic and home doing net of $30,000 a year. For full information write to Box 501 in care of the Journal.

FOR SALE: Schindler-Cameron flexible gastroscope, completely equipped and in perfect condition. Also a Boros-Cameron flexible esophagoscope (never used) with hooked handle. Completely equipped. Address replies to Box 503 in care of the Journal.

UNUSUAL OPPORTUNITY to do general practice in Madison, Wis., as associate and later partner. Well established practice. Salary open. Address replies to Box 494 in care of the Journal.

WANTED: Young, progressive clinic in Wisconsin needs obstetrician and gynecologist, certified or Board qualified, and general practitioner. Excellent opportunities. Address replies to Box 495 in care of the Journal.

FOR SALE OR LEASE: Doctors' medical building in Marinette, Wis., suitable for combination clinic and living quarters. Excellent location. Community of 30,000. Hospital facilities. Active medical practice has been carried on at this location for over 50 years. Write to H. L. Jorgenson, M. D., 8163 N. E. Second Avenue, Miami, Florida.

OPHTHALMOLOGY LOCATION WANTED: UW graduate, returning to Wisconsin for family and business reasons, wishes association with board member ophthalmologist. Training includes 3-year residency in EENT and basic science course in eye followed by several years of EENT practice. Could give excellent office and surgical assistance. Arrangements of association open. Address replies to Box 508 in care of the Journal.

EENT OFFICE FOR SALE OR RENT in community of 5,000 in east central Wisconsin. Owner retiring after 50 years of practice. Excellent 50-bed hospital. No charge for good will or introduction. Wonderful chance for right man. Address replies to Box 509 in care of the Journal.

GENERAL PRACTITIONER BADLY NEEDED in Adams-Friendship. Large practice with little competition. Local incorporated association ready to provide backing. Railroad guarantees at least $2,000 a year. Office and home available and rent free for 3 months. Hospital with ambulance facilities near by. Contact Harold T. Johnson, Adams, Wis.

FOR SALE: Medium size autoclave, two water sterilizers and instrument sterilizer (gas fired), excellent condition. Ideal for clinic or small hospital. Write I. Jansen, 723 Fifth Avenue, Antigo, Wis.

FOR SALE: Rhythmic constrictor with one cup. Very good condition. For information contact Mr. Robert Serns, 908 Linden Ave., Jefferson, Wis.

WANTED: Surgical assistant in general, thoracic, gynecologic, and industrial surgery. Prefer young man just finished with rotating internship, wishing some surgical training before going into general practice. Address replies to Box 504 in care of the Journal.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately. Write Box 505 in care of the Journal.

FOR SALE: Spencer microscope in carrier. Also other physician's instruments. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

MD WANTED for small group operating clinic and 25-bed modern hospital in rural town close to large city in southwest Wisconsin. $12,000 minimum first year, then partnership. Qualifications should include enough surgical experience to cope with accidents and major surgical emergencies. Excellent modern house available. Send details in first letter to Box 506 in care of the Journal.

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WHEN DIETARY SUPPLEMENTATION IS NEEDED...

what more could a supplement provide?

If the concept of an ideal dietary supplement could be formulated, it might well be one that provides qualitatively every substance of moment in human nutrition. It would provide those for which human daily needs are established as well as others which are considered of value, though their roles and quantitative requirements remain unknown.

How Ovaltine in milk approaches this concept, and how well the recommended three glassfuls daily augment the nutritional intake, is shown in the appended table. The two forms of Ovaltine available—plain and chocolate flavored—are closely alike in their nutrient values.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	10, 11, 23
American Meat Institute	16
Ames Company, Inc.	6
Ar-Ex Cosmetics	44
Audiphone Utilities	35
Ayerst, McKenna & Harrison, Ltd.	18
Barr X-Ray Company	37
Bayer Company	8
Benson Optical Company	4
Bergmann Prescription Center	25
Camel Cigarettes	17
Canada Dry Ginger Ale, Inc.	31
Central Drug	25
Ciba Pharmaceutical Products, Inc.	19
Cook County Graduate School of Medicine	37
Doerflinger Artificial Limb Co.	35
Endocrine Laboratories	36
Hotel Schroeder	5
House of Bidwell	37
Hurley X-Ray Company	35
Karrer Company	9
Keeley Institute	34
Kennedy-Mansfield	25
Knox Gelatine	38
Lederle Laboratories	facing page 18
Lilly, Eli and Company	20
Mallard, Incorporated	13
Mallatt Pharmacy	25
Mather Pharmacy	25
Mayer Drug	25
Mead Johnson and Company	51
Medical Protective Company	5
Milwaukee Sanitarium	52
New York Polyclinic	40
Orthopedic Appliance Company	40
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	7
Philip Morris	12
Physicians Casualty Association	40
Professional Business Service	405
Radium Emanation Corporation	27
Rennebohm's	25
Rogers Memorial Sanitarium	52
Sacred Heart Sanitarium	39
St. Croixdale Sanitarium	5
Searle, G. D. and Company	21
Shorewood Hospital Sanitarium	33
Stanley, Inc.	43
Summit Hospital	27
Time Insurance Company	403
Upjohn Company	15
Wander Company	47
Winthrop-Stearns, Inc.	14
Wisconsin Life Insurance Company	36

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia–Marquette–Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake–Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnle 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 AUGUST 1953 Number 8

The Treatment of Acne Vulgaris in Teen-age Males with Oral and Topical Administration of Estrogenic Hormone

By ARTHUR ANDREWS HOLBROOK, M. D.
Milwaukee

THE endocrine approach to the treatment of acne vulgaris was well outlined by Charles H. Lawrence[1] in 1936. He noted that though in 1896 Unna had associated acne with puberty, in the ensuing 25 years little attention was paid to this relationship. Lawrence treated acne with the anterior pituitary-like hormone (Antuitrin S). His studies led to valuable observations on androgen and estrogen excretions in women with acne. In 1940 the concept was published[2] that an increased ratio of androgen to estrogen was a significant factor in the pathogenesis of acne vulgaris. The following year, James B. Hamilton[3] presented an important paper embodying the current theories about acne as well as the results of his pertinent experiments with the administration of androgens to eunuchoid and castrated men, to prepubertal boys, and to ovariectomized women. He stated, "It appears incontrovertible that testosterone propionate . . . is able to produce an acneform reaction in susceptible subjects if present in the body fluids and tissues in sufficiently high and sustained concentrations." His studies of hormonal levels in blood and urine showed that "gonadotropic substance is not directly at fault and estrogens may be at normal or at low levels." In 1950 Way and Andrews[4] reviewed the literature regarding the relationship between hormonal imbalance and acne vulgaris.

Hollander and Schmitt[5] were the first investigators to report on the use of an estrogen by mouth for the treatment of acne in the male. Their paper, read in 1939, reported good results in 4 out of 19 cases. The next published remarks in this respect which I could find were made by Belisario, an Australian, who discussed the paper by Way and Andrews in 1950 and described his success with diethylstilbestrol. Subsequent articles on the subject have been written by Andrews, Domonkos, and Post;[6] Sulzberger and Witten;[7] and White and Lehmann.[8]

The topical application of estrogen in the treatment of acne vulgaris has been repeatedly advocated by Shapiro[9-11] for both men and women. On the other hand, Whitelaw[12] and Philip[13] independently obtained good results with similar treatment in adolescent males only. The background for this mode of hormone administration has been reviewed by Shapiro.[11]

Method of Study

1. Oral Technic

The study to be presented in this article was conducted at the Milwaukee Country Day School from Oct. 1, 1951, to June 1, 1952. Seventeen boys with acne vulgaris were invited to participate. Only 2 of them had received previous x-ray therapy; both enjoyed transient benefit. Five boys had been given lotions in the past, but only 1 could recall having been helped. The limited number of available cases precluded the use of a control series.

After histories and physical examinations were completed, sodium estrone sulfate (Premarin) in tablet form was prescribed in the amount of 1.25 mg. daily for 15 of the group and 0.625 mg. daily for the remaining 2. The boys were instructed to take the medication about the same time each day. The smaller dose was given merely because of milder skin involvement. No other kind of treatment was prescribed.

Casual check-ups were made in scattered fashion throughout the school year, and detailed surveys were made once a month. Besides an examination of the skin, particular attention was paid to regularity in therapy,

This study was aided by a grant from Ayerst, McKenna & Harrison, Ltd.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

changes in the breasts, and the individual's appraisal of his progress. After the first month the daily dose was raised to 1.875 mg. in 3 cases.

Results—Treatment orally was continuous from Oct. 1, 1951, to Feb. 1, 1952. Ten of the 17 subjects enjoyed definite improvement, which tended to progress favorably over the 4 month period. In 2 of these 10, the skin cleared entirely, while in the other 8 there was simply a diminution of at least 50 per cent in the rate of eruptions and in the size of the lesions. The skin was apparently unaffected in the remaining 7 cases except for 1, in which the disease was aggravated by the treatment. Otherwise, in the series as a whole, the only untoward effects occurred in the breasts. Six boys developed enlargement and tenderness of both breasts. In 1 of these cases, only the right breast was affected for the first 2½ months. Another 6 of the group noted only tenderness in their breasts, especially about the nipples. On subsequent discontinuing of the drug, the mammary signs and symptoms disappeared within 2 weeks in every case.

During the month of February all treatment was stopped. Three of the 10 patients who had improved promptly suffered exacerbations of their acne. The rest held their gains.

2. Topical Technic

In the last 3 month period of the project, 12 of the 17 boys were given conjugated estrogenic substance in a non-greasy base* to rub into the erupted skin areas once, twice, or three times daily depending upon the severity of the lesions. Nine of the 12 responded favorably. Four of these were subjects who had failed to derive benefit from the tablets, including the one whose condition had been aggravated. The remaining 5 had also been benefited by the oral therapy.

Comments

Certain features of the study are summarized in the accompanying table. It will be noted from the point of view of etiology that 12 of the boys gave a negative history for any known allergic conditions, but of the 12, 6 were convinced that diet played a part in their skin trouble. Eating chocolate, nuts, sundaes and rich foods and taking soft drinks to excess regularly aggravated the acne, whereas abstinence from items like these tended to improve their conditions. Every individual who had tried the effects of sun-tanning was impressed by the benefits derived. The percentages of improvement with estrogens listed in Table 1 are a crude index of averages estimated by the author on the basis of repeated physical examinations. The factor of dosage-actually-taken did not enter these appraisals. For instance, S. M. (Case 12) neglected to take the tablets about 50 per cent of the time and obtained only 50 per cent benefit. The same over-all results occurred with W. B. (Case 4.) However, from mid-December to February W. B. was 100 per cent regular in his medication and showed closer to 90 per cent improvement during that period. In other words, if full cooperation had been sustained over the 8 months, some of the percentages would undoubtedly have been more favorable.

Discussion

The current literature contains many allusions to the pioneer work of Lawrence and Werthessen.[2] They concluded that the ratio between estrogen and androgen is of basic importance in the etiology of acne vulgaris. The assumption is that acnegenesis results from the stimulating effect of an absolute or relative excess of androgenic steroids upon susceptible oil glands in the skin. Estrogens are thought to inhibit this effect, whether administered orally or topically, by restoring the normal hormonal ratio at the target level.

As indicated in the first paragraph, Hamilton found no supporting evidence for the ratio concept. Furthermore, recent experiments by White and Lehmann[8] have shown that "a uniform and consistent decrease in values for urinary 17-ketosteroids (occurs) concomitantly with diethylstilbestrol medication" in young men with acne vulgaris. This finding would suggest the presence of some mechanism beyond the mere raising of the blood level of estrogenic substance. The most likely explanation for the diminution of the 17-ketosteroid output, I should imagine, is that the stilbestrol suppressed the gonadotropic production of the pituitary. Incidentally, the therapeutic results on the skin lesions were disappointing in this particular study.

If one is willing to accept the general proposition that androgens seem to promote the development of acne vulgaris and that estrogens apparently block this sequence, then it is perhaps difficult to understand the

* Premarin cream, containing 1.25 mg. of sodium estrone sulfate per gram.

TABLE 1.—*A Summary of Some of the Clinical Features Found in the Series of 17 Boys.*

Case	Age	Severity Lesions	Duration Acne (Years)	History of Allergy	Benefit From		Maximum Daily Dosage		Improvement		Also Helped By	Remarks
					Sun	Diet	Tablets mg.	Cream Applied	%	Attributed To		
1. T.B.	14	F**	3	No	Yes	Yes	1.25	0	90	Tablets		Improvement subsequently well maintained with ultraviolet light.
2. J.B.	16	F**	4	No	Yes	No	1.25	Once	75	Cream	Tablets	Cream suppressed comedones more than tablets did.
3. T.B.	17	F** C** B**	4	No	Yes	No	1.25	B.I.D.	90	Cream		Tablets had no effect on skin; cream worked beautifully.
4. W.B.	16	F** C** B**	4	No	Yes	No	1.25	0	50	Tablets		Cream not used because of poor cooperation.
5. W.H.	17	F*	3	Hay fever Asthma	?	No	1.25	Once	95	Tablets		Improvement lasted at least 4 months after tablets were stopped.
6. S.J.	18	F**	4	No	Yes	No	1.25	Once	75	Tablets		The right breast alone was affected the first 2½ months.
7. J.K.	15	F** C** B**	2	No	Yes	Yes	1.25	Once	80	Cream	Tablets	"The cream takes the bumps away."
8. D.K.	17	F*	3	Hay fever Asthma	?	No	0.625	Once	80	Tablets	Cream	Slight of build.
9. T.K.	17	F*	4	No	Yes	Yes	1.25	Once	50	Cream	Tablets	Disliked tablets because of breast effects.
10. R.L.	16	F*	1	No	Yes	No	1.875	B.I.D.	0			Conscientious hormonal treatment failed. Later improved with acnomel.
11. B.L.	18	F*	1	Asthma	Yes	Yes	1.25	B.I.D.	80	Cream		Tablets ineffective. Cream worked well.
12. S.M.	17	F** C** B**	3	No	?	Yes	1.25	Once	50	Tablets		Cream ineffective. Tablets worked well.
13. J.M.	16	F** C**	3	No	Yes	No	1.875	B.I.D.	40	Cream		Despite 100% regularity and largest doses the tablets failed.
14. J.P.	16	F*** C*** B***	4	Hay fever	Yes	Yes	1.25	T.I.D.	75	Cream		Tablets aggravated lesions; cream suppressed them.
15. J.R.	15	F**	4	Hay fever Asthma	Yes	No	1.25	Once	80	Cream Tablets		Oral and topical methods were equally effective.
16. J.S.	15	F*** C**	2	No	Yes	Yes	1.875	0	0			Treatment stopped after 11 weeks. Later improved with acnomel.
17. T.S.	15	F*** C*** B***	2	No	Yes	Yes	1.25	0	0			Conscientious treatment stopped after 4 months.

F—Face
C—Chest
B—Back

*Comedones, small papules and pustules.
**Larger lesions in size and numbers.
***Advanced, numerous cystic and nodular lesions.

good results obtained with the use of gonadotropic hormone in the male. One might expect that this anterior pituitary-like hormone would stimulate the output of excessive amounts of androgens and thus aggravate any acneform lesions. The answer to this problem may be derived from the work of Maddock and Nelson,[14] who showed that chorionic gonadotropin can increase the urinary estrogen excretion in men with functioning testes by 5 to 16 times, whereas the 17-ketosteroid output merely doubles. Thus, in certain cases at least, the use of gonadotropin is tantamount to giving estrogens.

Though gaps in our knowledge are being gradually filled as indicated above, we still must admit that we do not know the exact cause of acne vulgaris. The subject of hormonal therapy immediately raises interesting questions as to dosage gradients and their stimulating or inhibiting effects on the pituitary gland as well as on the target tissues themselves. Is there possibly a sebaceotropic hormone elaborated by the pituitary of which we are as yet unaware? In any case it will take a great deal of research to discover the mode of action of estrogen upon the sebaceous apparatus of the skin.

Meanwhile clinical studies may be expected to yield clues to some answers and at least furnish practical experience. It is discouraging in reviewing my results to be un-

able to draw correlations between marked systemic effects, as exemplified by gynecomastia and such other variables as the dosage of estrogen, the disappearance of comedones, or other clear-cut skin changes. I could discover no way of predicting in a given case whether the oral or the topical route would be preferable. Therefore, I now begin treatment of acne in males with the cream preparation, hoping to avoid the tablets because of their untoward effects on mammary and spermatogenic tissues even though these disturbances disappear shortly after the drug is stopped.[15] The subject of contraindications to estrogen therapy in acne has recently been well presented by Payne.[16]

Summary

Seventeen teen-age boys were treated over an 8 month period with estrogens given in tablet form by mouth and applied in a cream base locally.

Better than 70 per cent improvement was obtained in 10 of the group. Five boys attributed the greater part of success to the cream, 4 to the tablets, and 1 considered the two methods of treatment equally effective. Less improvement in several other cases was probably due to lack of regularity in taking the medication. Three boys of the 17 experienced no benefit whatever.

Attention is called to our lack of knowledge as to the mechanism by which estrogenic hormone affects the sebaceous apparatus of the skin. It is hoped that more research in that direction will be stimulated by clinical studies like this one.

425 East Wisconsin Avenue.

REFERENCES

1. Lawrence, C. H.: Anterior pituitary-like hormone; clinical study of its effects in acne vulgaris, J.A.M.A. 106:983–987 (Mar. 21) 1936.
2. Lawrence, C. H., and Werthessen, N. T.: Endocrine dyscrasia of acne vulgaris in women, Endocrinology 27:755–758 (Nov.) 1940.
3. Hamilton, J. B.: Male hormone substance; prime factor in acne, J. Clin. Endocrinol. 1:570–592 (July) 1941.
4. Way, S. C., and Andrews, G. C.: Hormones and acne, Arch. Dermat. & Syph. 61:575–588 (April) 1950.
5. Hollander, L., and Schmitt, C. L.: Treatment of acne vulgaris with estrogenic hormone; clinical investigation, Pennsylvania M. J. 43:249–251 (Dec.) 1939.
6. Andrews, G. C., Domonkos, A. N., and Post, C. F.: Treatment of acne vulgaris, J.A.M.A. 146:1107–1113 (July 21) 1951.
7. Sulzberger, M. B., and Witten, V. H.: Symposium on diseases of skin; hormones and acne vulgaris, M. Clin. North America 35:373–390 (March) 1951.
8. White, C. B., and Lehmann, C. F.: Diethylstilbestrol therapy in young men with acne, A.M.A. Arch. Dermat. & Syph. 65:601–608 (May) 1952.
9. Shapiro, I.: Estrogenic treatment of acne vulgaris, J. M. Soc. New Jersey 46:128–129 (March) 1949.
10. Shapiro, I.: Estrogens by local application in treatment of acne vulgaris, A.M.A. Arch. Dermat. & Syph. 63:224–227 (Feb.) 1951.
11. Shapiro, I.: Topical estrogens, clinical effects and side actions, J. Clin. Endocrinol. & Metab. 12: 751–760 (June) 1952.
12. Whitelaw, M. J.: Treatment of adolescent acne with topical application of estrogens, J. Clin. Endocrinol. 11:487–491 (May) 1951.
13. Philip, A. J.: Topical estrogens in acne vulgaris, New York State J. Med. 51:1313–1314 (May 15) 1951.
14. Maddock, W. O., and Nelson, W. O.: The effects of chorionic gonadotropin in adult men, J. Clin. Endocrinol. & Metab. 12:985–1014 (Aug.) 1952.
15. Emmens, C. W., and Parkes, A. S.: Vitamins and Hormones, New York, Academic Press Inc., 1947.
16. Payne, S. A.: Estrogen therapy in acne; contraindications, Ann. West. M. & S. 6:92–94 (Feb.) 1952.

MARQUETTE SCHEDULES FIRST FALL POSTGRADUATE PROGRAM

A one-day forum in diabetes mellitus will open the fall postgraduate program at the Marquette University School of Medicine on September 19.

Dr. Francis R. Keating, Jr., consultant in medicine at the Mayo Clinic, will be the guest speaker. The forum will be presented by Marquette's medical school in cooperation with the Wisconsin Diabetes Association.

Dr. William Engstrom, associate professor of medicine at Marquette, will direct the forum. Reservations for the day, which includes a noon luncheon, should be made through the director of postgraduate programs, Marquette University School of Medicine.

Indications for the Billroth I Partial Gastrectomy*

By LOUIS E. FAZEN, JR., M. D.
Racine

THE surgical approach to gastric lesions and duodenal ulcer has become needlessly standardized along the lines of the Polya or modified Hofmeister partial gastrectomy. Too frequently, modern surgeons overlook the clear-cut advantages in selected cases of the more physiological Billroth I gastroduodenostomy. Present-day surgical textbooks commonly refer to this procedure with only historical interest.

The Billroth I operation, first performed in 1881, was the first and most logical type of reconstruction of gastrointestinal continuity after partial gastrectomy. (Fig. 1) It has been utilized infrequently in recent years by American surgeons but has enjoyed more favor in Europe, where the Schoemaker modification was developed.[1] (Fig. 2) This accomplishes a more extensive gastric resection, especially along the lesser curvature, and eliminates the blind corner in the Hofmeister technic. Unless the method is accomplished with dispatch and without tension on the suture line, it is not applicable to the case at hand.

The Billroth I is especially indicated in cases of benign gastric ulcer with low gastric acidity,[2] although it will reduce gastric acidity as effectively as any other type of resection of equal extent.[3] Other gastric lesions are equally amenable to treatment by this method, and good results have been reported in a series of cases of carcinoma of the antrum.[4,5] In benign gastric ulcer, the extent of the resection does not seem as important as in duodenal ulcer,[6,7] but 75 per cent of the stomach can readily be resected after adequate and careful mobilization of the duodenum and the proximal segment of the stomach. Even esophagoduodenostomy can be performed by the experienced surgeon in some cases of total gastrectomy. The duodenum is mobilized by medial rotation after incision through the lateral peritoneal fold, and the proximal gastric segment is mobilized by completely freeing the lesser curvature side and dividing the left gastric vessels and the left gastroepiploic vessels. The blood supply to the remaining portion of the stom-

* Figures 1 and 2 reproduced from Marshfield Clinic Bulletin, August 1952; courtesy of C. L. Holmes, M. D.

Fig. 1—Billroth I anastomosis and its various modifications. Date on each drawing is that of the original publication.

ach is more than adequate and is derived from the short gastric vessels, the distal esophageal vessels, and branches from the phrenic vessels.

The Billroth I procedure should not be performed if it will compromise the extent of the intended resection or will result in tension on the suture line. It might be contraindicated by fixation, edema, or inflammation of the duodenum which could prevent adequate mobilization or would jeopardize healing of the suture line.

The very considerable advantages of the Billroth I partial gastrectomy in selected cases include the following points. It is the quickest and easiest method of accomplishment. Since there is only one suture line, the danger of duodenal stump leakage or blowout is eliminated. Normal anatomic gastrointestinal continuity is re-established, placing the duodenum, which is less susceptible to ulceration than the jejunum, next to the stomach. Nutrition is better than after a Polya or Hofmeister anastomosis,[8] and physiologic function more nearly approaches normal. The incidence of recurrent ulcer is low after the Billroth I resection and, if it does occur, further surgical treatment is not so difficult as with marginal gastrojejunal ulcer. In fact, in selected cases of gastrojejunal ulcer, further resection with a Billroth I anastomosis gives excellent results.[9] The response to intensive medical treatment is usually poor with gastrojejunal ulcer, but is commonly excellent in recurrent duodenal ulcer after a Billroth I resection.[7,10] The incidence of fatal gastrointestinal hemorrhage is two to three times higher in gastrojejunal ulcer than it is in gastric or duodenal ulcer.[11] The Billroth II modifications also carry with them the possibility of development of a gastrojejunocolic fistula. The distinctly lower surgical mortality in the Billroth I operation reflects the lesser surgical trauma and less handling of tissues and accounts for the tendency to use this procedure in the elderly, debilitated, or poor-risk patient.[12] Postoperatively there are fewer complications[4] and less difficulty with digestion, nutrition,[13] intestinal motility, or dumping syndrome than with any other type of resection.

Report of a Case

A 74 year old white man, J. M., came to us with the complaint of epigastric pain of three years' duration. He was relieved by eating or by drinking hot water and felt accentuation of the pain when hungry or with ingestion of soda pop or alcoholic beverages. He complained of swelling of the abdomen at intervals for the previous month, occurring after eating and relieved partially by belching. There had been no vomiting or hematemesis, but he had been very consti-

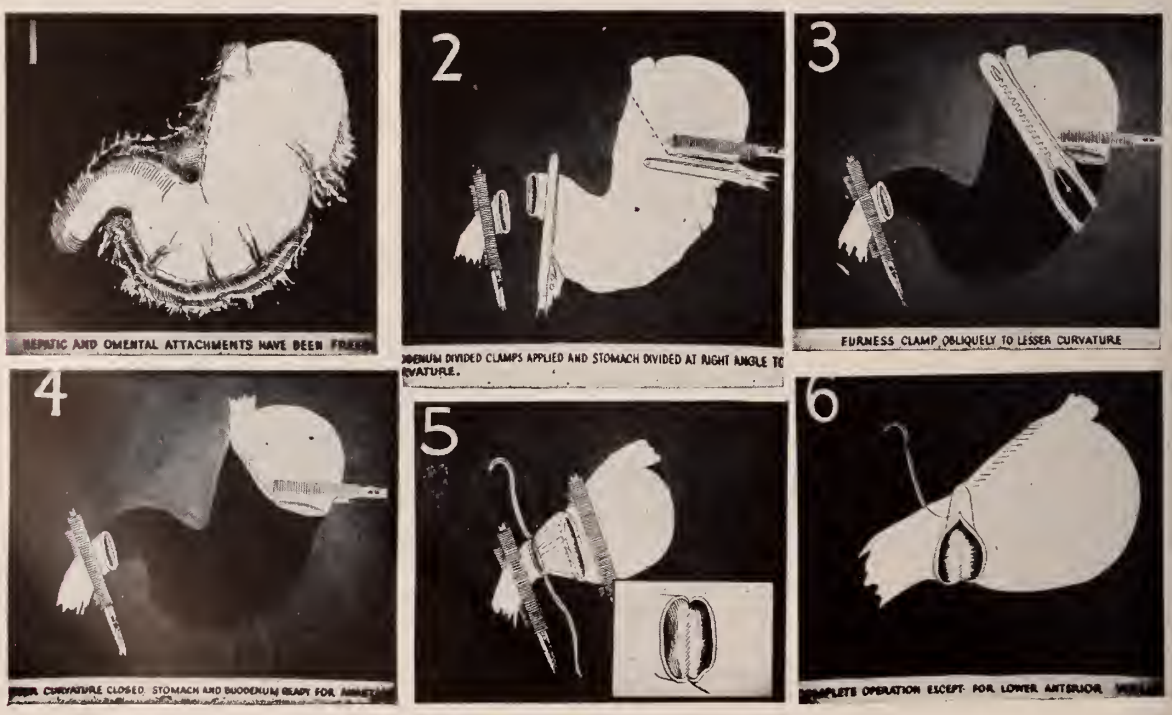


Fig. 2—Billroth I Schoemaker modification. (Photographs of drawings)

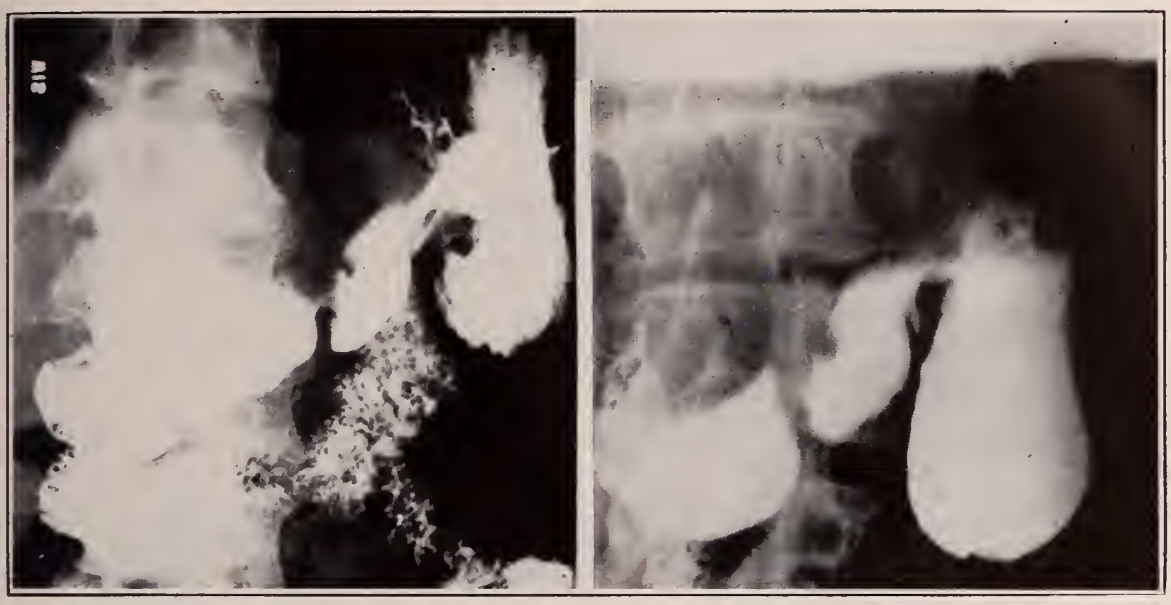


Fig. 3—Deformity of stomach due to adhesions and recurrent gastric ulcer (ulcer not seen on x-ray).

pated for years. Past history revealed that he had undergone a wedge resection of a large gastric ulcer of the lesser curvature six years before. There had been no known weight loss.

The patient was edentulous; he had a small bilateral inguinal hernia, and a well-healed left paramedian upper abdominal postoperative scar; the lungs were loaded with rhonchi and scattered crepitant rales. Postural drainage produced only a small amount of morning sputum.

X-rays of the chest and gallbladder and an intravenous pyelogram were not remarkable. Gastrointestinal series revealed an hour-glass deformity of the stomach with no visible ulcer crater and with considerable four-hour retention of barium. (Figs. 3 and 4)

The hemoglobin was 13 Gm., the red blood cell count was 4,060,000, and the leukocyte count was 5,300. Urinalysis was negative. Prothrombin time was 100 per cent of normal, blood sugar 93 mg. per cent, serum bilirubin 0.35 mg. per cent, nonprotein nitrogen 64 mg. per cent, urea nitrogen 16.5 mg. per cent, creatinine 1.4 mg. per cent, and plasma protein 6.1 Gm. with an albumin-globulin ratio of 1.3/1.

The histamine gastric analysis revealed a hypochlorhydria with negative occult blood in all specimens. The blood volume was normal by the Evans blue dye method. Proctosigmoidoscopy was negative. The patient was prepared for surgery during a 14 day period

Fig. 4—Four-hour film showing gastric retention and narrow channel connecting proximal and distal segments of the stomach.

of hospitalization with blood transfusions, parenteral vitamins, and a high protein, high carbohydrate, high calorie diet. Laparotomy was then performed and a Schoemaker modification of the Billroth I partial gastrectomy was accomplished. Rather extensive intra-abdominal adhesions were encountered; the gastric deformity was found to be due to omental adhesions and the inflammatory reaction from a recurrent gastric ulcer of the

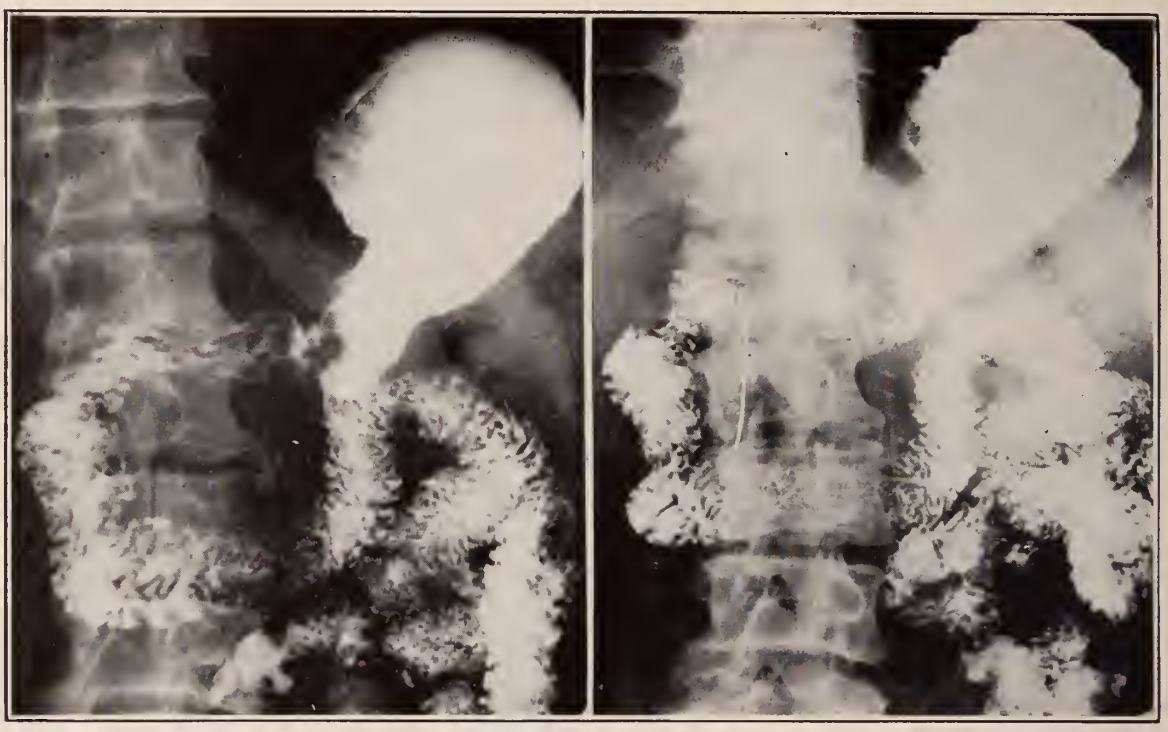


Fig. 5—Anteroposterior and oblique views taken one month postoperatively reveal normal gastrointestinal continuity restored.

lesser curvature at the incisura angularis. Study by our pathologist revealed that the ulcer was benign.

The patient experienced an unusually smooth convalescence and was discharged on the twelfth postoperative day; at that time his diet consisted of bland foods with six meals a day.

One month postoperatively, x-rays revealed barium passing through the stomach at a normal rate, with no four-hour retention. There was no evidence of fluoroscopic tenderness or marginal ulceration. (Fig. 5) He stated that he was now eating better than before the operation, his bowels were moving regularly without laxatives, and he was sleeping better than he had in several years.

Summary

The Billroth I partial gastrectomy is a very valuable procedure in selected cases and has not received the consideration it merits by American surgeons. It has a lower mortality rate than Billroth II modifications and results in fewer postoperative complications. A case has been presented of a 74 year old man with a recurrent gastric ulcer who had a smooth and uneventful convalescence after a Schoemaker modification of the Billroth I partial gastrectomy.

725 Main Street.

REFERENCES

1. Schoemaker, J.: Zur Technik der Magenresektion nach Billroth I, Arch. f. klin. Chir. 121:268-271, 1922.
2. Monteiro, A., and Barreto, H.: Aseptic gastric resection, Billroth I technique, Surgery 23:178–184 (Feb.) 1948.
3. Clagett, O. T., and Waugh, J.M.: Indications for and advantages of Schoemaker–Billroth I gastric resection, Arch. Surg. 56:758–765 (June) 1948.
4. Friedell, M. T.: Billroth I type of operation for carcinoma of the stomach, Proc. Staff Meet. Mayo Clin. 16:481–487 (July 30) 1941.
5. Walters, W., and others: Carcinoma and Other Malignant Lesions of the Stomach. Philadelphia, W. B. Saunders Co., 1942.
6. Ivy, A. C., Grossman, M. I., and Bachrach, W. H.: Peptic Ulcer. Philadelphia, The Blakiston Co., 1950.
7. Brown, C. H., and Hoerr, S. O.: Marginal ulcer following gastric resection for benign gastric ulcer, Cleveland Clin. Quart. 19:213–218 (Oct.) 1952.
8. Wollaeger, E. E., and others: Total solids, fat, and nitrogen in feces; study of persons who had undergone partial gastrectomy with anastomosis of entire cut end of stomach and jejunum (Polya anastomosis), Gastroenterology 6:93–104 (Feb.) 1946.
9. Balfour, D. C.: The status of "Billroth No. 1" in the surgery of the stomach and duodenum, editorial, Surg., Gynec. & Obst. 58:917–919 (May) 1934.
10. Horsley, J. S.: Billroth I type of partial gastrectomy, South. M. J. 35:456–461 (May) 1942.

11. Walters, W., and Cleveland, W. H.: Results of partial gastrectomy for bleeding duodenal, gastric ,and gastrojejunal ulcer, Ann. Surg. 114:481–497 (Oct.) 1941.
12. Maingot, R.: Abdominal Operations, ed. 2. New York, Appleton–Century–Crofts, Inc., 1948.
13. Barden, R. P., Ravdin, I. S., and Frazier, W. D.: Hypoproteinemia as a factor in the retardation of gastric emptying after operations of the Billroth I or II types, Am. J. Roentgenol. 38:196–202 (July) 1937.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 37 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	3:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:45 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Rooming-in and the Private Hospital

By F. JACKSON STODDARD, M. D.
Milwaukee

ROOMING-IN is the hospital arrangement whereby a mother may have her newborn baby in a crib by her bedside whenever she wishes.

History of Rooming-In

Artificial separation of the newborn child and mother was introduced in hospitals in the United States at the turn of the century. The new mother often was seriously ill and the obstetrician wished to let her rest away from the sight and sound of her baby. Furthermore, it was believed that keeping the newborn under the watchful eye of specially trained pediatric nurses in well-scrubbed nurseries gave the infant a better start in life. Thus, maternity floors and nurseries have kept pace with scientific developments during the last 50 years and have contributed dramatically to improved maternal and neonatal death rates.

But while focusing on aseptic technic and improving mortality rates, an important factor was unintentionally overlooked. This was the emotional relationship of mother and child.

In an attempt to remedy this oversight and to avoid the errors of raising children by what has been called "the book," a group of psychiatrists, psychologists, and pediatricians met in Detroit, Mich., in November 1942. From this group came recommendations that ushered in a new era in neonatal and infant care. They discouraged artificial separation of the newborn child from its parents, advocated breast feeding whenever the child is hungry and anxious, and advised less regimentation in the care of infants. This idea now goes by the name "rooming-in." Rooming-in has been tried extensively and successfully at Yale,[1-9] George Washington University Hospital,[10] Jefferson Medical College Hospital,[11-13] Duke University Hospital,[14] and Permanente Hospital,[15] in Oakland, California.

Early in 1948 arrangements were made for patients to room-in at Columbia Hospital. From Jan. 1, 1948, to Dec. 31, 1951, 55 patients chose this plan.

Description of Columbia Plan

The program is optional for mothers who have normal deliveries and when neither mother nor child needs special care. Patients have learned of the plan either from friends, obstetricians, pediatricians, or mothers' classes. The hospital has charged the patients the same as for routine care. To date all patients have been in private rooms, but should two mothers who deliver at about the same time desire it, they may be placed in a two-bed room. The program is begun 24 to 96 hours post partum, and averages 40 hours. It is felt that careful nursery observation of the newborn during at least the first 24 hours, or until the mucus has been aspirated, is the safest procedure. Other than the nurse and doctor, the father is the only visitor permitted to handle the baby. A sun porch is provided where the mother may see her other visitors. If the mother's rest is unduly disturbed by the baby, the baby is returned to a separate nursery at night. It is felt that a flexible policy is in the best interest of the purposes of rooming-in. The rooming-in mother has a bassinet by her bedside and nursery supplies for the care of the baby. The nursery nurses stop in several times a day to make suggestions to the patient and answer her questions. In addition, each patient has a direct telephone connection to the nursery. These are the essential features of the plan, which has undergone minor modifications as experience has increased.

Purposes of Rooming-In

The proponents of rooming-in are generally agreed on the purposes which it aims to accomplish. Under proper guidance this program aids the mothers in developing confidence in caring for their babies. The father is able to evaluate his role from the start and adjust himself to it. Breast feeding is encouraged though not compulsory.

Semi-demand feeding with breast or bottle is facilitated in a way not possible with usual nursery routine. The chances of epidemic diarrhea and other nursery infections are decreased. It gives the psychological lift to

both the mother and the baby which prevailed before the modern nursery for the newborn.

Patient Reaction

In an effort to evaluate the Columbia program, the following questionnaire was sent to the 55 mothers who participated in the program between January 1948 and January 1952. There were 45 replies.

Was rooming-in pleasant?

Yes	36
No	6
Yes, But	3

Would you room-in again with first baby if you had it to do over again?

Yes	39
No	4
Yes, But	2

If you have more babies do you plan to room-in?

Yes	27
No	13
Yes, But	5

How soon after delivery would you like to begin rooming-in?

Immediately	8
24 hours	14
48 hours	15
Longer	6
No answer	2

How long did you nurse your baby?

2 weeks or less	6
2 weeks to 2 months	9
2–4 months	12
4 months or more	10
0	2

For what reason did you stop nursing?

Sore nipples	4
Insufficient milk	17
Wanted to	9
Still nursing	7
Baby trouble	5
Miscellaneous	3

Other than for breast feeding did you feel rooming-in profitable?

Yes	41
No	4

What were your husbands reactions to rooming-in?

Favorable	42
Unfavorable	2
?	1

How many children do you hope to have?

Two	9
Three or four	28
More than four	5
?	3

Parity of patients at time of rooming-in experience:

First baby	43
Second baby	6
Third baby	4
Fourth baby	1
Seventh baby	1

Typical Comments About Program

"Wonderful to be able to handle and cuddle baby at will."

"Now I'm not terrified to be alone with the baby."

"The mother is sure her baby is not being neglected."

"I'd never seen so small a baby before, much less known how to handle one."

"I became acquainted and at ease with baby, used to the noises and habits of baby. Makes it easier when you get home and have no one to help you."

"Helped me understand the baby and his care. Nothing to fear now that I'm self-reliant and can enjoy my baby."

"Fine for fathers. Fathers' enthusiasm one of best features of rooming-in."

Discussion

The answers to the questionnaire enthusiastically support the natural common sense of the rooming-in program. The few critical responses came from patients who had wanted to room-in but who were not indoctrinated well enough ahead of time to cooperate fully. The program seemed to be well suited for multipara who had had some unpleasant experience with nursery care during previous deliveries. With rooming-in the mother was now "certain" of her baby's condition. After returning home, patients who had roomed in made fewer phone calls to their doctors than those who had had routine care. The number of rooming-in mothers shows only a slow increase, probably because of the deeply ingrained, usually fallacious idea that a new mother is a sick mother. Certainly, the mother who goes home on her fifth postpartum day, often with only part-time unskilled help, will have a less fatiguing puerperium if she has had firsthand experience in caring for her baby.

Whether the cost of mother and infant care will be different with greater patient participation is not known. The experience at other institutions indicates that rooming-in costs the hospitals no more than routine hospital care for obstetrical floors.

Conclusions

1. Rooming-in is desirable and feasible without special facilities in private hospitals.
2. Patients should be taught the details of the program well before delivery. Their participation should never be compulsory.
3. Primiparae and multiparae who have had unpleasant previous hospital experiences form the vast majority of patients who elect the rooming-in program.
4. Nearly all of the patients were favorably disposed toward the program.
5. Continuation and expansion of rooming-in is planned as patient demand increases.

Perhaps future generations who are given a little more love and permissive care in infancy will add less to the confusion of the world than those of us who were nurtured on a strict four-hour schedule.

425 East Wisconsin Avenue.

REFERENCES

1. Jackson, E. B.: Should mother and baby room together? Am. J. Nursing 46:17–19 (Jan.) 1946.
2. Jackson, E. B., and Thoms, H.: Rooming-in plan for mothers and newborn infants, Connecticut M. J. 11:175–176 (March) 1947.
3. Jackson, E. B.: Mothers and babies together, Parents' Magazine 22:18. (Oct.) 1947.
4. Jackson, E. B.: Theoretic considerations and parental observations relating to unified hospital care of mother and infant, Proceedings of Third American Congress on Obstetrics and Gynecology, pp. 8–17, 1947.
5. Jackson, E. B., and others: Hospital rooming-in unit for 4 newborn infants and their mothers; descriptive account of background, development, and procedures with a few preliminary observations, Pediatrics 1:28–43 (Jan.) 1948.
6. Jackson, E. B.: "Rooming-in" gives baby a good start, Child 12:162–165 (April) 1948.
7. Jackson, E. B.: General reactions of mothers and nurses to rooming-in; observations based on experience in 4 bed rooming-in unit in Grace–New Haven Community Hospital (University Service), Am. J. Pub. Health 38:689–695, May (pt. 1) 1948.
8. Thoms, H., Jackson, E. B., Stowe, L. M., and Goodrich, F. W., Jr.: Rooming-in plan for mothers and infants; appraisal from obstetric viewpoint on one year's experience at Grace–New Haven Community Hospital (University Service), Am. J. Obst. & Gynec. 56:707–711 (Oct.) 1948.
9. Jackson, E. B.: Pediatric and psychiatric aspects of Yale rooming-in project, Connecticut M. J. 14: 616–621 (July) 1950.
10. McLendon, P. A., and Parks, J.: Nurseries designed for modern maternity, Mod. Hosp. 65:46–49 (July) 1945.
11. Montgomery, T. L.: Bedside care of newborn by parturient mother, M. Clin. North America 32: 1699–1709 (Nov.) 1948.
12. Montgomery, T. L., Steward, R. E., and Shenk, E. P.: Observations on the rooming-in program of baby with mother in ward and private service, Am. J. Obst. & Gynec. 57:176–186 (Jan.) 1949.
13. Montgomery, T. L., and Shenk, E. P.: Further experiences with rooming-in project of baby with mother, Pennsylvania M. J. 52:1085–1091 (July) 1949.
14. The rooming-in experiment: 1. Plans and problems, E. C. Waddell, 2. Experiences and reactions, Duke (Durham, N. C.) Hospital Staff, Hospitals 22:44–48 (Aug.) 1948.
15. Diddle, C. F.: Don't start a rooming-in program . . . unless you are prepared to continue it, Mod. Hosp. 75:79–80 (Nov.) 1950.
16. Strong, R. A.: Rooming-in the newborn with its lying-in mother, Diplomate 21:301–309 (Dec.) 1949.

CHEST PHYSICIANS ANNOUNCE POSTGRADUATE COURSES

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Eighth Annual Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, Illinois, September 28–October 2, 1953, and the Sixth Annual Postgraduate Course on Diseases of the Chest to be held at the Hotel New Yorker, New York City, November 2–6, 1953.

These annual postgraduate courses endeavor to bring physicians up to date on recent advancements in the management and treatment of heart and lung disease. Tuition for each course is $75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Madison, Wisconsin

Preventable Anesthesia Disturbances

Modern drugs and new methods of administration pose special problems for the anesthetist. Careful choice of the anesthetic agent, as well as special care in its administration, is of increasing importance with the wider selectivity now available.

Anesthetic difficulties and fatalities, when they occur, are due almost exclusively to some interference with the efficiency of the respiratory and circulatory systems, causing a deficiency in oxygenation. The dosage of anesthetic agents, particularly of the rapid-acting agents, must be carefully controlled to prevent respiratory depression. Mechanical obstruction is another common cause of respiratory depression. It is imperative that each patient be closely observed during induction until individual tolerance can be accurately determined. Faulty position of the head, lingual relaxation, enlarged tonsils and adenoids, misplaced dentures, or the presence of foreign bodies such as chewing gum interfere with adequate gaseous exchange. Removal of foreign bodies and insertion of an oropharyngeal or nasopharyngeal airway will usually correct these conditions.

Inhalation of too strong an anesthetic vapor or the presence of vomitus, mucus, or blood on the vocal cords may precipitate varying degrees of laryngospasm. Immediate removal of the offending agent and aspiration, followed by positive pressure on the breathing bag containing oxygen for a few breaths, usually overcomes the spasm. Other conditions which may lower respiratory efficiency include the diaphragmatic and intercostal paralysis coincident to high spinal analgesia, pneumothorax, and mediastinal shift during chest surgery. Mechanical assistance of the respiratory exchange by rhythmic manual compression of the breathing bag is necessary to overcome the poor expansion of the thorax.

Circulatory complications during anesthesia are dramatic and may appear very suddenly. Arterial hypotension may be due to primary, secondary, or vasogenic shock. Primary shock is associated with a rapid increase in size of the vascular bed from sympathetic paralysis or from reflex neurogenic stimuli and can be controlled frequently by the administration of vasopressor drugs. Careful attention to fluid loss and its rapid replacement is essential in the prevention and treatment of secondary shock. The alterations associated with the abnormal capillary permeability of vasogenic shock may be improved by the administration of adrenal cortical extract. The management of cardiac arrest which presents the greatest emergency has been discussed previously.

Prevention of many of the serious problems which lead to fatalities may be accomplished by stricter attention to the patient during anesthetic induction. Immediate correction of even minor disturbances is essential. Cancellation of cases undergoing difficult and traumatic induction and simplification and rapid termination of an operation because of developing complications may be necessary. The Wisconsin Anesthesia Study Commission presents several cases illustrating these points.

CASE 46—This 42 year old man gave a history of recurrent hypertension for the past 10 years. A sympathectomy performed 8 years before relieved symptoms for 6 years. Symptoms gradually returned and he had a cerebral vascular accident with a left-sided paralysis 2 years before. Residual left-sided numbness and weakness persisted. At the present time there was marked dyspnea, orthopnea, and weekly episodes of dizziness and syncope. Headaches were severe and the patient complained of paroxysms of chest pain lasting 1 to 3 seconds and requiring Demerol medication for relief. The factor of drug addiction was suspected. Medical management of the hypertension had not been satisfactory and he was admitted for evaluation and repeat sympathectomy. Electrocardiogram demonstrated severe myocardial changes with left ventricular strain. A Regitine test for adrenal tumor was negative.

Preoperative medication was 10 mg. of morphine sulfate and 0.3 mg. of scopolamine. Blood pressure was 210/140. After the intravenous administration of 0.5 per cent Surital and 40 mg. of succinyl choline, the patient was orally intubated with a #35 French-cuffed Portex tube. Exposure was difficult and the vocal cords were not visualized. Anesthesia was continued with a mixture of nitrous oxide and oxygen by semiclosed to-and-fro absorption technic. The patient was placed in the prone position and the surgical preparation of the skin was completed. The incision was outlined and towel clips were put in place. At that time the anesthesiologist was unable to palpate a pulse or hear a blood pressure. Respiration stopped. The patient was turned immediately on his back and artificial respiration was started. Within a few minutes a peripheral pulse was perceptible and the systolic blood pressure was 180 mm. of mercury. Spontaneous respirations returned without difficulty. Thirty minutes later the patient was returned to his room. Oxygen was continued by nasal catheter and 1,000 cc. of 5 per cent dextrose in water was administered. Blood pressure was recorded at 164/134. An hour later he was responding and appeared in satisfactory condition. He was discharged two days later without any untoward effects.

CASE 47—A 5 year old child was admitted for tonsillectomy. She had had "flu" during the past week and had a residual nonproductive cough. An immediate preoperative examination of her throat and lungs was negative for evidence of infection. Rectal temperature was 99.8 F.

She received 0.15 mg. of scopolamine subcutaneously and induction of anesthesia was started with a high flow of cyclopropane, nitrous oxide, and oxygen, open technic. The addition of ether on the open mask was followed by a severe laryngospasm initially diagnosed as breath-holding. The laryngospasm persisted and the child became cyanotic. The anesthesiologist was unable to inflate the child's lungs by using positive pressure with a bag and mask. The child became pale and a peripheral pulse beat was not palpable. Approximately 6 minutes had elapsed since the start of anesthesia. The vocal cords were exposed immediately and were completely closed. No secretion or vomitus was seen in the pharynx. Intubation was performed without undue difficulty and mouth-to-tube ventilation was started. Color improved rapidly and a pulse beat became palpable. Respirations resumed spontaneously soon afterwards.

During the process of intubation, the surgeon was preparing to open the child's thorax and start cardiac massage. However, by this time, artificial ventilation had been instituted and resulted in rapid improvement, and thoracotomy with massage was not necessary. The child regained consciousness and responded 9 minutes after the onset of circulatory collapse. The operation was cancelled and she recovered without any complication or evidence of cerebral damage.

CASE 48—A 75 year old obese white female had a sudden onset of severe right upper quadrant pain. When she was admitted to the hospital 24 hours later, she appeared jaundiced and was dyspneic. Three weeks before, she had been started on digitoxin medication. Examination revealed auricular fibrillation with a ventricular rate of 120 beats per minute, moist rales at both lung bases, and marked right upper quadrant tenderness. Blood pressure was 126/? and nonprotein nitrogen was 60 mg. per cent. A diagnosis of acute cholecystitis with cholelithiasis and congestive heart failure was made and she was continued on supportive treatment. An electrocardiogram taken during this period suggested an acute posterior wall infarct. Auricular fibrillation continued with a ventricular rate of 90 beats per minute. A chest x-ray showed bilateral chronic fibrous pleurisy with minimal pleural effusion at the left lung base.

There was slow but gradual improvement with medical management over a period of 6 weeks. Urinary output increased and nonprotein nitrogen was 35 mg. per cent. An abdominal exploration with cholecystostomy was contemplated. Premedication of 0.3 mg. of scopolamine was given and anesthesia was maintained with cyclopropane by to-and-fro absorption technic. At the start of the operation 12 mg. of d-tubocurarine was given intravenously. The gallbladder filled with stones was removed and because of the history of jaundice and its dilated appearance, the common bile duct was explored but no stones were found. An appendectomy was also performed. During the course of the total anesthetic time of 1 hour and 45 minutes, the patient's condition remained stable. She was continued on oxygen by nasal cath-

eter postoperatively. Respirations were rapid and shallow and intermittent periods of cyanosis occurred. Pulse was weak and thready and the systolic blood pressure was never recorded above 78 mm. of mercury. She died 9 hours later without regaining consciousness. Cause of death was attributed to circulatory failure. The pathologist reported the presence of adenocarcinoma of the gallbladder.

Comments

Episodes of hypotension occasionally follow position changes in the anesthetized patient, especially in older, debilitated, and obese individuals. The first patient had the additional factor of a previous surgical sympathectomy with the inherent tendency to instability of the autonomic nervous system. The possibility of ganglionic blockade resulting from the relaxing agent used to facilitate intubation must be considered.

The residual irritation of the respiratory tract following the "flu" undoubtedly was a factor in the reaction of the child to induction. Laryngospasm from the fumes of an irritating vapor will usually disappear when the anesthetic mask is removed from the face and the vapor concentration lowered. In this instance, the spasm persisted and the child was beginning to show vascular changes due to severe hypoxia. The fact that intubation was fairly easy in spite of apparently closed vocal cords indicated the onset on relaxation which precedes death from hypoxia. Quick action in initiation of good artificial ventilation probably prevented severe damage and cardiac arrest.

The decision to postpone the operation in both these cases was wise although the individuals responded well with correction of bad situations. The additional surgical trauma, if permitted, might very well have been the "insult to injury" which would have precipitated irreversible changes.

The third patient was a very poor operative risk. The use of curare may have been a poor choice in an obese, debilitated patient who had known cardiac damage. Low respiratory exchange with concurrent hypoxia predisposes an individual to postoperative shock, vascular collapse, and respiratory complications. An anesthetist should not "play along" with a bad situation in the hope that the operation will be over soon. It is his responsibility to keep the surgeon informed of changing events during the course of an operation and, if necessary, urge the termination of the procedure because of developing complications.

Adherence to the basic principles of anesthesia, namely, maintenance of a clear airway with adequate respiratory exchange, recognition of the signs of anesthesia, and the avoidance of an overdose of the anesthetic drug, may stop the progression of complications which result in irreversible changes and fatalities. Emphasis must be on prevention of these alterations rather than the treatment which so often is unsuccessful.

REFERENCES

1. Gould, R. B.: Preventable anaesthetic deaths; reflections on modern anaesthesia, Anaesthesia 6:100–109 (April) 1951.
2. Lorhan, P. H., and Wright, E. M., Jr.: Acute anesthetic emergencies, J. Kansas M. Soc. 52:421–424 (Sept.) 1951.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3, and 4, 1953, inclusive, at the Palmer House, Chicago, Ill.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2, and 3. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

Role of Family Physician in Children's Emotional Problems

As It Looks to Your State Board of Health

PARENTS who are troubled by their child's behavior turn first to their family physician for help. The complaint with which they come may seem trivial to him. He may feel the child will "outgrow it." There is often a temptation to tell them to go home and "forget about it." But parents who have become disturbed enough to face such a problem cannot ignore it. They are already too anxious and concerned. This, in itself, may increase the difficulties.

Even in pre-school years, children develop conflicts that form the basis for later emotional problems. Parent-child relationships are the focus of maladjustments throughout life. Since it is in the early years that these are established, it is in the early years, when prevention is most effective, that help must be given.

Most physicians recognize that more than 25 per cent of their patients are ill primarily because they cannot cope with the stresses and strains of life. Physical complaints or symptoms may have developed because of this. It is estimated that most antisocial behavior has its start before 19 years of age. Ten per cent of the nation's population becomes disabled to a lesser or greater degree sometime during life because of psychologic disorders. This problem must be reached through prevention. It becomes the responsibility of the family physician to do what he can as early as he can about child behavior problems.

Behavior disorders in children all have meaning. They are the symptoms which signify that the child is having difficulty in meeting life's demands. The symptom may be thumbsucking, lying and stealing, a feeding difficulty, bowel or bladder complaints, overactivity, negativism, shyness and withdrawal, inadequate school achievement, fears, nightmares—anything from an apparently simple problem to one that looks alarmingly serious. The difficulties may arise because of structural, physiologic, or organic defects or intellectual, social, or emotional stresses. It is necessary to evaluate the presenting symptom, to recognize its underlying meaning, and to decide whether the child must be referred for special study or whether he can be handled more simply.

Some of the criteria for making this decision follow. Parents may have their own special reasons for being sensitive to a certain kind of behavior in their child, not recognizing that it is perfectly normal. The behavior may simply express a phase of development through which all children go. This they will outgrow—but only if conditions encouraging such growth and development are provided. It is truly a problem if emotional development has been arrested, fixated at an immature level. It is a serious problem if the behavior is regressive—if the child has gone back to a more primitive infantile level. If the behavior is inappropriate to the situation, if it is grossly exaggerated, persistent, or resistant to all well-considered measures to modify it, expert help is needed.

One of the resources where such help can be obtained is the child guidance center. Such a center is made up of a child psychiatrist, a clinical psychologist, and a psychiatric social worker who cooperatively study all the factors that may be contributing to the child's problem. This is done through individual contacts with parents and child. Such a study includes thorough knowledge of the child's physical status, a social case history, psychologic testing, analysis of emotional reactions, and an understanding of inter-personal and intra-personal conflicts.

After diagnostic study has been completed, conferences with the referring physician make it possible for him to work out plans with the staff for a therapeutic program based on understanding what the needs of the child are that are not being met. Together they can explore the ways in which these needs can be met and the problems resolved. This may be by modification of the environment, by attitudinal treatment, or by individual psychotherapy. Recognizing the cases and giving or getting for the child the help he needs is the family physician's most important contribution in preventing emotional disorders.—EUGENIA S. CAMERON, M. D., *Director, Division of Child Guidance.*

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Does Exertion Precipitate Coronary Thrombosis?

Despite much recent discussion no unanimity of opinion has as yet developed regarding the relationship, if any, between physical exertion and the average case of coronary thrombosis or infarction. Recently, J. L. Richardson[1] presented his views and considerations on this problem. He states: "It is an established fact that hemo-concentration, slowing of the blood flow, or any factor which makes the blood clot quicker, will favor the formation of thrombi in the coronary or any other artery." Clinically, it is already well established that early postoperative ambulation has significantly decreased the incidence of thrombotic or embolic accidents. At this point one might well state that though coronary arteries are much like arteries in any other location, obstruction of a coronary artery results in a much more dramatic episode than an obstruction in almost any other area.

It is a common belief that exertion may precipitate a coronary episode, and that those episodes which occur while an individual is active are to be ascribed to the effects of that activity on circulatory demands. The clinical histories obtained often reveal that the patient had been doing some physical work just before the attack occurred. But such histories do not record the times when the same patient had previously been doing some physical work without any penalizing coronary episode as a consequence of that work. Therefore there must be some other or additional factor to explain the phenomenon. It is statistically established that approximately one half of the "cardiac" deaths had their apparent inception during sleep; obviously it would be difficult to relate coronary accidents to physical activity in such circumstances. In this connection, one may recall that the "depth" of sleep at various intervals of time within the sleeping period can be represented by recording quantitatively the amount of stimulus required to waken a subject. There is usually a rather sudden increase in the strength of a stimulus necessary to awaken a person shortly after sleep sets in. This reaches its maximum in approximately 15 to 30 minutes and continues with minor variations for about 4 hours. A rather shallow sleep then gradually develops which continues through a second period of approximately 4 hours. In this latter period normal muscle tone then becomes re-established. A person feels "groggy" if awakened within the first 4-hour period, but this feeling progressively diminishes throughout the second 4-hour period. Blood pressures generally parallel the depths of sleep. Such being the case, it then might be of signal interest to accumulate data on the actual time of death relative to the parts of the sleeping period. If there is a coincident frequency relationship between the time of death or time of coronary attack and the physical relaxation or depth of sleep, there would then be some sound basis for ascribing the high incidence of death during sleep to the different circulatory states. A sluggish circulation in the state of deep depression in sleep and the accompanying muscular relaxation can conceivably predispose to thrombosis in those "coronary cases" in which thrombosis can be established at autopsy. In many instances, however, thrombosis cannot be found in individuals dying from "coronary disease," so probably hypoxia of heart muscle with a resulting coronary spasm would have to be assumed.

As pointed out by Richardson, the relationship of physical effort to coronary attack may well be much less real than commonly supposed. Perhaps the evidence has its parallel in accidents happening to people who have just recently "walked under a ladder" —in other words, the relationship may be largely coincidental. To ascribe coronary accidents to relaxation and to the recuperative phases of sleep would not immediately appeal to the minds of laymen as sound and practical reasoning. In order to sleep, one must assume the risks involved. To be alive at all constitutes a certain liability. To ascribe coronary accidents generally to some prior physical effort comes a long way from being

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

realistic scientific logic. Finally, it has been suggested that subintimal hemorrhage may be occurring or may have occurred to narrow the lumina of coronary vessels, hence leading to local ischemia of the cardiac musculature. Does this suggestion harmonize with the rather current doctrine of using anticoagulants to retard coagulation in such cases?—A. L. TATUM, M. D.

REFERENCES

1. Richardson, J. L.: Does exertion precipitate coronary thrombosis? J.M.A. Georgia 42:89–91 (Feb.) 1953.

ANNUAL MEETING WISCONSIN CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Milwaukee, Sunday, October 4, 1953

1:00 p. m. **Registration and Viewing of Exhibits:** 5th Floor

2:00 p. m. **Scientific Program:** Crystal Ballroom: 5th Floor

Electrocardiographic Problems in Daily Practice: A. Helmuth, M. D., Chicago, Illinois

Granulomatous Lung Disease: Joseph M. Lubitz, M. D., Milwaukee

Surgical Treatment of Mitral and Aortic Stenosis: Alfred Goldman, M. D., Los Angeles, California (Motion Pictures)

Inhalation of Dyhydrostreptomycin Dust in the Treatment of Diseases of the Respiratory Tract: Mary Karp, M. D., Edward E. Avery, M. D., et al., Chicago, Illinois

Diseases of the Trachea: Kenneth C. Johnston, M. D., Chicago, Illinois (Motion Pictures)

6:00 p. m. Dinner: Club Rooms, 3rd Floor
Address: **Palliative Treatment of Inoperable Bronchogenic Carcinoma:** Edgar Mayer, M. D., New York, New York

Annual Meeting

MILWAUKEE ★ OCTOBER 6-7-8

Scientific Program Highlights

20 Nationally Famous Physicians as Guest Speakers
Daily Teaching Demonstrations

"Special Emphasis" Programs:

TUESDAY, OCT. 6

Anesthesia
▪
Medicine and Psychiatry
▪
Orthopedics

WEDNESDAY, OCT. 7

Cardiac and Pulmonary Diseases
▪
Obstetrics and Gynecology
▪
Pathology

THURSDAY, OCT. 8

Pediatrics
▪
Radiology
▪
Surgery
▪
Ophthalmology and Otolaryngology

Condensed Time Table

SATURDAY, OCTOBER 3

7:00 p.m.: Interim Committee; Milwaukee Athletic Club

SUNDAY, OCTOBER 4

3:00 p.m.: Council Meeting; Club Rooms, Hotel Schroeder
6:30 p.m.: Council Dinner; Club Rooms, Hotel Schroeder

MONDAY, OCTOBER 5

9:30 a.m.: First Session, House of Delegates; East Room, Hotel Schroeder
1:00 p.m.: Luncheon, House of Delegates; Ballroom, Hotel Schroeder
1:00 p.m.: Golf Tournament; North Hills Country Club
3:00 p.m.: Reference Committees
6:30 p.m.: Dinner and Awards; North Hills Country Club

TUESDAY, OCTOBER 6

9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
9:00 a.m.: Reference Committees; Hotel Schroeder
10:15 a.m.: Scientific Sessions; Milwaukee Auditorium
(Anesthesia, Internal Medicine and Psychiatry, Orthopedics)
12:15 p.m.: Luncheons; Hotel Schroeder
2:00 p.m.: General Scientific Session; Milwaukee Auditorium
2:00 p.m.: Second Session, House of Delegates; East Room, Hotel Schroeder
5:30 p.m.: Art Reception; Milwaukee Art Institute
7:15 p.m.: Buffet Dinner in connection with Art Show; Pfister Hotel

WEDNESDAY, OCTOBER 7

8:30 a.m.: Third Session, House of Delegates; East Room, Hotel Schroeder
9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:15 a.m.: Scientific Programs; Milwaukee Auditorium
(Cardiac and Pulmonary Diseases, Obstetrics and Gynecology, Pathology)
12:15 p.m.: Luncheons; Hotel Schroeder
12:15 p.m.: Marquette Alumni Luncheon; Blatz Auditorium
2:00 p.m.: General Scientific Session; Milwaukee Auditorium
5:30 p.m.: President's Reception; East Room, Hotel Schroeder
6:45 p.m.: Annual Dinner, Dance, and Floor Show; Ballroom, Hotel Schroeder

THURSDAY, OCTOBER 8

9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:15 a.m.: Scientific Programs; Milwaukee Auditorium
(Pediatrics, Radiology, Surgery)
12:15 p.m.: Luncheons; Hotel Schroeder
12:15 p.m.: Luncheon and Section Program, Section on Ophthalmology and Otolaryngology; East Room, Hotel Schroeder
2:00 p.m.: Closing Scientific Session; Ballroom, Hotel Schroeder

Special *Notice For*

E. J. McCORMICK, M.D.

DELEGATES, COUNCILORS, AND OFFICERS

On Monday, October 5, there will be a special luncheon for all delegates, councilors, officers, and invited guests, with Doctor E. J. McCormick, president of the American Medical Association, as the principal speaker. Arrangements will be made to have representatives of important state associations in attendance, as well as board members of the Medical Auxiliary.

Because of changes in meeting days the following schedule will be followed for meetings of the House of Delegates and related groups:

Monday, Oct. 5

9:30 a.m.: First Meeting of the House of Delegates; East Room, Hotel Schroeder, Milwaukee.

1:00 p.m.: Special luncheon honoring Doctor McCormick; Ballroom, Hotel Schroeder.

3:00 p.m.: Reference Committees. Meetings will be held by all reference committees to organize and to hear delegates and members who wish to appear.

Tuesday, Oct. 6

9:00 a.m.: Reference Committees—continued meetings until 11:00 a.m.

2:00 p.m.: Second Meeting of the House of Delegates; East Room, Hotel Schroeder.

(This meeting will adjourn not later than 4:30 p.m. so that all delegates can join their wives for the Art Exhibit reception at the Milwaukee Art Institute at 5:30 p.m., and the buffet dinner and program at the Hotel Pfister at 7:15.)

Wednesday, Oct. 7

8:30 a.m.: Third Session of the House of Delegates; East Room, Hotel Schroeder.

Hotel Rooms . . .

The Hotel Schroeder will accept room reservations for delegates, officers, and councilors on a preferential basis if received by September 1. All delegates, officers, and councilors have been sent special forms for this purpose. To be assured of accommodations at the headquarters hotel, these blanks must be sent to the hotel before September 1.

Special Feature *Daily Oct. 6-7-8*

DEMONSTRATION SCHEDULE

Each Morning
9:00–10:00

Direct, practical teaching in important areas of medicine. One hour of informal instruction, purposely planned for small groups. All teaching programs located on or near stage of Exhibit Hall in Milwaukee Auditorium. Get there early and enjoy this special feature of the program.

ANATOMY: The Department of Anatomy at Marquette University School of Medicine, under the direction of Walter Zeit, Ph.D., Director, will offer dissections to indicate the anatomical landmarks and hazards of a tracheotomy, and will also present a cut-away section of the spinal column, demonstrating the position of the spinal needle in a lumbar puncture.

OB & GYN: Members of the Wisconsin Society of Obstetrics and Gynecology will conduct daily manikin demonstrations to illustrate special problems of delivery, and when possible will correlate this with outstanding teaching films. Opportunities for questions and audience discussion will be provided.

FRACTURES: The Wisconsin Orthopedic Society will again demonstrate the proper application of plaster casts for fractures of the humerus and fractures about the ankle. Medical students will be used as "patients." Demonstrators will welcome a presentation of special problems by those present. The demonstrations will be under the direction of Joseph R. Stone, M.D., Milwaukee.

CEREBRAL PALSY: The Cerebral Palsy Center, Milwaukee, will present a "live" demonstration with the use of children, occupational therapists, and physicians, who will present methods of evaluation and treatment. The role of the family physician in carrying on methods of treatment on the local level will be stressed. This problem may confront you at any time, so become acquainted with modern methods of treatment and a knowledge of services available to you. Demonstrations under the direction of Raymond Waisman, M.D., Milwaukee, Director of the Cerebral Palsy Center.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present daily discussions on gross pathology, with the use of specimens of greatest interest to the general practitioner. Demonstrations under the direction of Gorton Ritchie, M.D., Milwaukee.

PRYDE and DAY

LEJAREN à HILLER

Special Features for MDs and Wives

THE STORY OF MEDICINE IN ART

TUESDAY OCT. 6 The Milwaukee Art Institute, in cooperation with the Boston Store, the Medical Society of Milwaukee County, and the State Medical Society, proudly presents an outstanding art exhibit entitled "The Story of Medicine in Art," consisting of paintings, lithographs, and other expressions of art directly related to medicine. Galleries from all over America have loaned works for this show, which will be featured during the Annual Meeting. On Tuesday, Oct. 6, these special features are provided:

RECEPTION AND SPECIAL SHOWING: At 5:30 p.m., Oct. 6, the Milwaukee Art Institute will hold a special reception for doctors and wives who are attending the buffet supper and special evening program at the Hotel Pfister. The reception will be at the Art Institute, and special tours are arranged between 5:30 and 7:00 p.m.

BUFFET DINNER AND SPECIAL PROGRAM: At 7:15 p.m. there will be a buffet dinner at the Hotel Pfister, with Lejaren à Hiller, New York City, internationally famous photographer and illustrator, as the featured speaker.

ANNUAL DINNER ★ DANCE ★ FLOOR SHOW

WEDNESDAY OCT. 7 Something different! No long speeches! Just fun! The Annual Dinner is planned as a period of relaxation and good fellowship.

STEVE SWEDISH AND HIS ORCHESTRA will play during dinner and provide music for dancing between courses.

50 YEAR CLUB AWARDS: New members of the 50 Year Club will be honored guests, and will receive their awards after dinner.

PROFESSIONAL FLOOR SHOW: As a feature of the program there will be a full hour of high-class professional entertainment, which will conclude the Annual Dinner.

LIMITED ATTENDANCE AT EACH OF THESE EVENTS . . . GET YOUR RESERVATIONS FILED IMMEDIATELY BY USE OF THE BLANK ON PAGE 457

Schedule of

SCIENTIFIC PROGRAMS—TUES., OCT. 6

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES
GROSS TISSUE
ANATOMY DISSECTIONS
OBSTETRICS AND GYNECOLOGY
THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 446 For Full Descriptions)

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

ANESTHESIA: Walker Hall, Milwaukee Auditorium

Moderator: John Temple, M.D., Milwaukee

9:00: Business Meeting, Wisconsin Society of Anesthesiology.

10:15: **General Anesthesia for the Patient with Cardiac Disease:** John W. Pender, M.D., assistant professor of anesthesiology, University of Minnesota Graduate School, Mayo Foundation.

10:45: **Infant Resuscitation:** William Kreul, M.D., Racine.

11:05: **Anesthesia for Cardiac Surgery:** William O. McQuiston, M.D., instructor in surgery, Northwestern University, and attending anesthesiologist, Children's Memorial Hospital, Chicago.

MEDICINE AND PSYCHIATRY: Juneau Hall, Milwaukee Auditorium

Moderator: Francis L. Hummer, M.D., Madison

10:15: **Psychological Needs of the Medically and Surgically Ill Patient:** David A. Boyd, Jr., M.D., professor of psychiatry, University of Minnesota Graduate School, Mayo Foundation.

(Rogers Memorial Lecture)

10:45: **New Developments in Anticoagulant Therapy:** John Hirschboeck, M.D., dean, Marquette University School of Medicine.

11:15: **The Relationship of Hormones to Carcinoma:** Joseph C. Aub, M.D., professor of research medicine, Harvard Medical School, Boston.

(Lecture sponsored by Wisconsin Division of the American Cancer Society)

PICTURES, FROM TOP TO BOTTOM: Joseph C. Aub, Boston; David A. Boyd, Jr., Rochester, Minn.; William T. Green, Boston; G. Edmund Haggart, Boston.

ORTHOPEDICS: Kilbourn Hall, Milwaukee Auditorium

Moderator: George L. Thomas, M.D., Janesville

10:10: **Disability Evaluation:** Chester C. Schneider, M.D., Milwaukee.

10:30: **Management of Low Back and Sciatic Back Pain:** G. Edmund Haggart, M.D., chief, department of orthopedic surgery, Lahey Clinic, Boston.

11:00: **Reconstructive Surgery in Poliomyelitis:** William T. Green, M.D., clinical professor of orthopedic surgery, Harvard Medical School, Boston.

(Lecture sponsored by National Foundation for Infantile Paralysis)

Round Tables, Tuesday, Oct. 6

[AT HOTEL SCHROEDER]

1. WM. O. MCQUISTON, Peoria: **Pediatric Anesthesia**
2. G. E. HAGGART, Boston: **Further Discussion of the Management of Low Back and Sciatic Back Pain**
3. DAVID BOYD, Rochester, Minn., and OWEN CLARK, Oconomowoc: **Recognition of the Depressed Mental State**
4. W. S. MIDDLETON, Madison: **Newer Drugs and Their Uses**
5. JOSEPH AUB, Boston: **The Metabolism of Bone**
6. F. J. HOFMEISTER, Milwaukee: **Bleeding in the Last Trimester**
7. PAST PRESIDENTS' LUNCHEON
8. J. L. SIMS, Madison: **Problems in the Management of Hepatitis and Cirrhosis**
9. JAMES CONLEY, Milwaukee: **Surgical Problems in the Diabetic**
10. MR. J. P. REVENAUGH (Professional Business Management), Chicago: **Business Practices in the Doctor's Office**
11. JOHN GONCE, JR., Madison: **Problems in Infant Feeding**
12. STURE A. M. JOHNSON, Madison: **Infections of the Hair and Nails**
13. JOHN CURTIS, Madison: **New Concepts in Antimicrobial Therapy in Tuberculosis**

Afternoon Scientific Assembly

JUNEAU HALL—MILWAUKEE AUDITORIUM

Moderator: T. O. Nuzum, M.D., Janesville, Chairman, Council on Scientific Work

2:00: **The Treatment of Diseases of the Lymph Nodes:** Ovid O. Meyer, M.D., professor of medicine, University of Wisconsin Medical School.

2:20: **Early Treatment of Poliomyelitis:** William T. Green, M.D., Boston.

2:50: RECESS TO VIEW EXHIBITS

3:30: **Lesions of the Lower Colon:** Paul Shallenberger, M.D., clinical professor of medicine, Hahnemann Medical School, Philadelphia.

4:00: **Complications in Anesthesia Related to Cortisone Therapy:** John W. Pender, M.D., Rochester, Minn.

PICTURES. RIGHT: John W. Pender, Rochester. BOTTOM, LEFT TO RIGHT: William O. McQuiston, Peoria, Ill.; Paul Shallenberger, Philadelphia.

Schedule of

SCIENTIFIC PROGRAMS—WED., OCT. 7

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES

GROSS TISSUE

ANATOMY DISSECTIONS

OBSTETRICS AND GYNECOLOGY

THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 446 For Full Descriptions)

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

CARDIAC AND PULMONARY DISEASES: Kilbourn Hall, Milwaukee Auditorium

Moderator: Francis Rosenbaum, M.D., Milwaukee

10:15: **Medical Management of Hypertension with Particular Reference to Hypotensive Drugs:** Joseph H. Hafkenschiel, M.D., associate in medicine, University of Pennsylvania Medical School, Philadelphia.

10:45: **Electrolyte Disturbances of Heart Disease:** Charles K. Friedberg, M.D., assistant professor of clinical medicine, College of Physicians and Surgeons, Columbia University, New York City.
(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

11:15: **Surgical Management of Unresolved Pneumonia:** William M. Tuttle, M.D., associate professor of clinical surgery, Wayne University, Detroit.

OBSTETRICS AND GYNECOLOGY: Juneau Hall, Milwaukee Auditorium

(Official meeting of the Wisconsin Society of Obstetrics and Gynecology, but all others welcome to attend.)

Moderator: George Stevens, M.D., Wausau, president of the Wisconsin Society of Obstetrics and Gynecology

10:10: **The Present Status of Myomectomy:** Joseph F. Egan, M.D., La Crosse.

10:30: **Urologic Complications in Obstetrics and Gynecology:** Lawrence R. Wharton, M.D., assistant professor of gynecology, Johns Hopkins University, Baltimore.

11:00: **Vascular Complications of Pregnancy:** Conrad G. Collins, M.D., professor and chairman, department of obstetrics and gynecology, Tulane University School of Medicine, New Orleans.

11:30: Short Business Meeting of Wisconsin Society of Obstetrics and Gynecology.

PICTURES, TOP TO BOTTOM: Conrad G. Collins, New Orleans; Elbert De Coursey, Washington, D. C.; Charles K. Friedberg, New York City; Joseph H. Hafkenschiel, Philadelphia.

PATHOLOGY: Walker Hall, Milwaukee Auditorium

Moderator: Dann Claudon, M.D., Milwaukee

10:10: **The Medicolegal Aspects of Sudden Death:** L. J. Van Hecke, M.D., associate professor of pathology, Marquette University, Milwaukee.

10:30: **The Pathology of Hemorrhagic Fever:** Brig. Gen. Elbert DeCoursey, M.D., director, Armed Forces Institute of Pathology, Washington, D. C.

11:00: **Tumors in Childhood:** Gorton Ritchie, M.D., Milwaukee.

11:20: Short Business Meeting of Wisconsin Society of Pathologists.

Round Tables, Wednesday, Oct. 7

1. C. G. Collins, New Orleans: **Management of Preeclampsia and Eclampsia**
2. C. K. Friedberg, New York: **Management of Intractable Heart Failure**
3. Wm. M. Tuttle, Detroit: **Diagnostic Difficulties in Carcinoma of the Lung**
4. Ovid Meyer, Madison: **Newer Drugs and Their Uses**
5. Paul Shallenberger, Sayre, Pa.: **Peptic Ulcer**
6. Leslie Osborn, Madison: **Psychiatric Services in General Hospitals**
7. Kenneth Winters, Wauwatosa: **Physician Responsibility in Care of the Premature**

Marquette Alumni Luncheon, Wednesday

If you plan to attend the free luncheon of Marquette Alumni at Blatz on Wednesday do not make reservations for any other luncheon. *Reservations for Marquette luncheon not made through SMS office, so do not list.*

8. C. S. Rife, Milwaukee: **Problems in the Management of the Acute Abdomen**
9. A. C. Edwards, Racine: **The Relationship of Public Health to the Practicing Physician**
10. Brig. Gen. E. DeCoursey, Washington, D. C.: **Tissue Reaction to Ionizing Radiation**

Afternoon Scientific Assembly

JUNEAU HALL—MILWAUKEE AUDITORIUM

Moderator: Joseph W. Gale, M.D., General Program Chairman, 1953 Annual Meeting

2:00: **Arterial Hypertension as Determined by the Success of Certain Medical or Surgical Procedures:** Joseph H. Hafkenschiel, M.D., Philadelphia.

2:30: **Non-operative Treatment of Stress Incontinence in Women:** Lawrence R. Wharton, M.D., Baltimore.

3:00: RECESS TO VIEW EXHIBITS

3:30: **Thoracic Trauma:** William M. Tuttle, M.D., Detroit.

4:00: **Newer Methods of Diagnosis and Therapy in Office Gynecology:** Conrad G. Collins, M.D., New Orleans.

PICTURES, TOP TO BOTTOM: William M. Tuttle, Detroit; Lawrence R. Wharton, Baltimore.

Schedule of

SCIENTIFIC PROGRAMS—THUR., OCT. 8

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES

GROSS TISSUE

ANATOMY DISSECTIONS

OBSTETRICS AND GYNECOLOGY

THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 446 For Full Descriptions)

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

PEDIATRICS: Walker Hall, Milwaukee Auditorium

Moderator: Niels Low, M.D., Racine

10:10: **Present Status of Epilepsy:** M. G. Peterman, M.D., Milwaukee.

10:30: **The Genetics of Epilepsy:** O. P. Kimball, M.D., chief of medical staff, Doctors Clinic, Cleveland.

11:00: **Status of Immune Globulin:** W. D. Stovall, M.D., director, State Laboratory of Hygiene, Madison.

11:20: Short Business Session of Section on Pediatrics.

RADIOLOGY: Kilbourn Hall, Milwaukee Auditorium

Moderator: Abraham Melamed, M.D., Milwaukee

10:15: **Comparative Evaluation of Deep Roentgen Therapy and Supervoltage Roentgen Therapy:** Traian Leucutia, M.D., assistant professor of radiology, Wayne University, Detroit.

10:45: **Spinal Cord Tumors:** S. A. Morton, M.D., and Robert Byrne, M.D., Columbia Hospital, Milwaukee.

11:05: **Hodgkin's Disease with Metastasis in Skull:** E. A. Pohle, M.D., and Wayne M. Rounds, M.D., University of Wisconsin Medical School, Madison.

SURGERY: Juneau Hall, Milwaukee Auditorium

Moderator: Frank D. Weeks, M.D., Ashland

10:10: **Diaphragmatic Hernia:** William P. Young, M.D., VA Hospital, Madison.

10:30: **Breast Carcinoma:** Robert M. Janes, M.D., professor and chairman, department of surgery, University of Toronto, Toronto, Canada.

(Lecture sponsored by Milwaukee Division of the American Cancer Society)

11:00: **Homografts, Fresh and Postmortem, as Biological Dressings for Burns:** J. Barrett Brown, M.D., professor of clinical surgery, Washington University Medical School, St. Louis, Missouri.

PICTURES, TOP TO BOTTOM: Oscar J. Becker, Chicago; J. Barrett Brown, St. Louis; Hermann M. Burian, Iowa City; Robert M. Janes, Toronto.

Round Tables, Thursday, Oct. 8

1. MILTON SENN, New Haven: **The Value of the Child Guidance Clinic to the Practicing Physician**
2. J. BARRETT BROWN, St. Louis: **Surgical Repair of Radiation Lesions, Including Those of Atomic Origin**
3. T. LEUCUTIA, Detroit: **Plesiotherapy and Teletherapy with Various Radioactive Sources**
4. FRANCIS D. MURPHY, Milwaukee: **Newer Drugs and Their Uses**
5. T. A. LEONARD, Madison: **Postpartum Management**
6. O. P. KIMBALL, Cleveland: **Epilepsy in Relation to Inheritance**
7. SILAS EVANS, Milwaukee: **Recent Advances in the Experimental Study of Atherosclerosis**
8. R. H. QUADE, Neenah: **Diagnosis and Treatment of Head Injuries**
9. DONALD M. RUCH, Milwaukee: **Occupational Dermatitis—Diagnosis and Management**
10. FRED W. MADISON, Milwaukee: **Hemolytic Anemias and Related Syndromes**
11. JOHN A. SCHINDLER, Monroe: **Psychosomatic Problems in General Practice**
12. F. D. WEEKS, Ashland: **Surgical Problems of the Biliary Tract**
13. LUNCHEON AND SCIENTIFIC PROGRAM OF SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

LUNCHEON AND PROGRAM

SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

EAST ROOM—12:15 P.M.—HOTEL SCHROEDER

Moderator: Gerhard D. Straus, M.D., Milwaukee

1:00: Business Meeting.

1:30: **Evaluation of Diagnostic Methods in the Examination of Neuromuscular Anomalies of the Eye:** Hermann M. Burian, M.D., professor of ophthalmology, State University of Iowa College of Medicine, Iowa City.

2:00: **Radical Surgery in the Treatment of Advanced Carcinoma of the Larynx:** Charles J. Finn, M.D., clinical instructor in otolaryngology, Marquette University, Milwaukee.

2:20: **Occlusion of the Central Retinal Artery:** C. G. Kirchgeorg, M.D., Neenah.

2:40: **The Septum in Relation to Rhinoplastic Surgery:** Oscar J. Becker, M.D., assistant professor of maxillofacial surgery, department of otolaryngology, College of Medicine, University of Illinois, Chicago.

CLOSING SCIENTIFIC ASSEMBLY

Ballroom, Hotel Schroeder

Moderator: P. A. Midelfart, M.D., Eau Claire, Member of Council on Scientific Work

2:00: **Rounded Shadows in the Chest:** Robert M. Janes, M.D., Toronto, Canada.

2:30: **Newer Developments in Radiation and Chemotherapy for the Treatment of Cancer:** Traian Leucutia, M.D., Detroit.

3:00: **What the Family Physician Should Know About Emotional Problems of Children:** Milton J. E. Senn, M.D., director, Yale University Child Study Center, Yale University, New Haven, Connecticut.

PICTURES, TOP TO BOTTOM: O. P. Kimball, Cleveland; Traian Leucutia, Detroit; Milton J. E. Senn, New Haven.

SCIENTIFIC EXHIBITS

Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups

S. A. MORTON, M.D.

The scientific exhibits listed below have been selected for the 1953 Annual Meeting by Dr. S. A. Morton, Milwaukee, a member of the Council on Scientific Work. The exhibits will be open in Bruce Hall of the Milwaukee Auditorium from 8:00 a.m. to 5:00 p.m. on Tuesday, October 6, and Wednesday, October 7, and from 8:00 a.m. to noon on Thursday, October 8.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

S-7a INCREASE FETAL SALVAGE?

Obstetrical Departments of St. Joseph's and Milwaukee Hospitals, Milwaukee

Objective: (1) Demonstration of the value of autopsies in all neonatal deaths and stillborn infants; (2) Demonstration of clinical means of obtaining higher fetal salvage.

S-8 THE USE OF THE SCINTILLATION COUNTER FOR THE MEASUREMENT OF THYROID FUNCTION

Department of Isotopes of Marquette University School of Medicine, Irving I. Cowan, M.D., Mr. Frank Karioris, Miss Pauline Dolezar, Miss Rita Szejna, and Miss Elizabeth Lawton

The exhibit will consist of the following: (1) Actual exhibit of the scintillation tube and the counting equipment plus a radiation source for demonstration purposes. (2) Description of the tracer technic using the scintillation counter. (3) Demonstration of the advantages of the use of the scintillation counter over other types of equipment. (4) Presentation of several case reports illustrating the clinical application of this method of measuring thyroid function.

S-9, 10 EARLY AND LATE TREATMENT OF BURNS

Frank D. Bernard, D.D.S., M.D., Department of Surgery, University of Wisconsin Medical School

The exhibit will offer a pictorial representation of the immediate care of a severely burned patient and a chronological follow-through of dressing technics, indications for skin grafts, and care after grafting has taken place. Also included will be the care of a chronic open burn wound as well as the evaluation and care of contractures and deformities following severe burns.

S-11 PHYSIO-ANATOMICAL ASPECT OF GASTRIC ULCER FORMATION

Drs. H. B. Benjamin, Walter Zeit, and Marvin Wagner, and Mr. Eugene Hauschalter, Department of Anatomy, Marquette University School of Medicine

This exhibition presents a physio-anatomical approach to the possible causative factor of gastric ulcers. In this demonstration of our experiments we show the variations which occur in the intragastric temperatures as they are recorded before and during the hunger phase, on patients who have active peptic ulcers, and on the complicated peptic ulcer cases. An intragastric thermapile was employed to obtain these temperatures.

It was noted in our experiments that approximately one-half hour after the patient's desire for food the temperature took a sharp dip to a lower level and shortly after became elevated to its previous or near-previous plateau. It was felt that this reaction took place because the muscular contractions of the stomach arrested the blood flow and led to a dearth of oxygen and the reduction of regional metabolism.

This contention is based on the work done at our institution on the neurovascular mechanism of the stomach, where we have demonstrated that in the stimulated stomach the mucous membrane is kept in a state of anemia because of the shunting mechanism of the vascular bed. This latter work will

also be demonstrated in our exhibit by slides and photographs.

Our demonstration will include live patients. Intragastric temperatures will be recorded and graphs and placards will be used to demonstrate the various curves obtained on various patients.

S–12, 13 SIGMOIDOSCOPY

Paul L. Shallenberger, M.D., and Peter Fisher, M.D., Guthrie Clinic, Sayre, Pa.

Sigmoidoscopy has been an excellent means of detecting early tumor formation and is useful in the recognition of other diseases. The examination is simple and is easily performed by any physician with a minimum of training. We have studied our results in a group of 4,500 consecutive cases examined and the results are tabulated. Some discussion of the various lesions seen with technics of biopsy are included. About 10 per cent of these examinations disclosed tumor formation; 7.6 per cent of these were found on microscopic examination to be benign and 2.7 per cent were malignant. Sixty-five per cent of the cases examined revealed pathological conditions. Many of these could be easily and quickly corrected medically or surgically with complete relief of distress to the patient.

The value of this examination is emphasized and it is urged that it be included as a part of the physical examination, particularly in the over-forty age group.

S–14, 15 NOISE IN INDUSTRY

Meyer S. Fox, M.D., and Paul J. Whitaker, M.D., Milwaukee

This exhibit will deal with the problems relating to hearing impairments resulting from prolonged exposure to high intensities of industrial noise. The physical characteristics of sound and the responses of the human ear to sound will be evaluated. Audiograms taken from case studies found in otologic practice will be shown. These records will illustrate early, moderate, and severe hearing losses and will demonstrate their effects upon hearing and communication. Recommendations for hearing conservation programs in industry based upon findings from current research will be outlined, and various types of ear plugs and defenders will be exhibited. Equipment for evaluating the characteristics of sound (sound level meters and octave band analyzers) as well as instruments for measuring acuity and discrimination ability of human hearing (pure tone and speech audiometers) will be demonstrated.

S–16, 17 THE TOXEMIAS OF PREGNANCY

Wisconsin Academy of General Practice

Although the maternal mortality rate from such causes as sepsis and shock resulting from blood loss has been greatly reduced since the advent of antibiotics and the establishment of blood banks, the toxemias of pregnancy continue to take their toll of fetal and maternal lives.

The key to successful treatment of the toxemias of pregnancy is primarily preventive in nature. Adequate prenatal care should assure every pregnant woman of a gestation uncomplicated by toxemia, especially of the more severe variety. Indeed, the development of severe preeclampsia or eclampsia in such a patient should prompt a reevaluation by the physician of the true adequacy of the care rendered that individual.

S–18, 19 DERMATOLOGIC LESIONS SEEN IN GENERAL PRACTICE

Richard Rowe, M.D., and J. B. Miale, M.D., Marshfield Clinic, Marshfield

The exhibit is a combined demonstration on the part of a dermatologist and a pathologist of the clinical and pathological aspects of the more common skin lesions which a general practitioner might be expected to see in his everyday practice. These will be presented in the form of large transparencies in color, with attached descriptive legends on which the differential diagnosis, histopathology, and treatment of choice will be outlined. Most of the common lesions will be illustrated, as well as a few of the more unusual lesions which are still within the scope of a general practitioner.

S–20, 21, 22 COORDINATED EXHIBITS OF VA HOSPITAL, WOOD, AND MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

1. PAINFUL AFFECTIONS OF THE SHOULDER: Mark W. Garry, M.D.

Considerable confusion exists about the recognition and interpretation of signs and symptoms associated with painful affections of the shoulder. Painful shoulder due to purely local lesions usually is limited to one of three categories: tendinitis, rotator cuff syndrome, or musculotendinous tears. Anatomical charts and printed signs will be used to define the pathogenesis of these disorders. Fuller understanding of the origin and evolution of these disorders is of paramount importance to the early, effective application of definitive treatment.

2. THE VITAMIN A TOLERANCE TEST FOR DIAGNOSIS OF CHRONIC PANCREATITIS: Bruno Peters, M.D., Joseph M. Lubitz, M.D., and Margaret M. Kaser, Ph.D.

The exhibit will summarize our studies of laboratory function tests for chronic pancreatitis. There will be about seven charts arranged in a prefabricated unit. These will show colored photographs of chronic pancreatitis and the various laboratory tests used on our patients. The interpretation of the vitamin A tolerance test will be stressed. The principles of the test will be stated. Charts will illustrate the vitamin A response in normal cases, cases of pancreatitis, and cases of sprue. Representative case histories will be presented.

3. HEMISPHERECTOMY IN THE TREATMENT OF MALIGNANCIES OF THE BRAIN (PHYSIOLOGIC STUDIES): David Cleveland, M.D.

Complete removal of one hemisphere of the brain has been carried out in a series of patients with recurring malignant gliomas of the brain. All of the patients were in the end phase and were extremely poor surgical risks. There has been a fifty per cent survival and one patient with an extremely malignant glioblastoma has survived and has been gainfully employed for four and a half years. Physiologic studies, including intensive sensory examinations, have been made and are

illustrated in stereoscopic slides. An attempt has been made to illustrate hemispherectomy and its effects by stereoscopic viewing.

S-23,24,25 SECTION ON RADIOLOGY

This exhibit will consist of new and recent developments in radiology which are of importance to the field of medicine in general and are of particular importance in the diagnosis of disease by x-ray. The exhibits have been especially prepared for the education of those less familiar with the subject rather than for specialists in radiology.

A list of the specific titles for the exhibits and the contributors are as follows:

1. DISPLACEMENTS OF THE SPINE: A. Melamed, M.D. and A. Marck, M.D., Milwaukee
2. SOFT TISSUE PLACENTOGRAPHY: M. Moel, M.D., Milwaukee
3. CHONDRO-DISPLASIA & RELATED DISORDERS: Donald Babbitt, M.D., Milwaukee
4. LUMBAR SPINE: S. A. Morton, M.D., R. W. Byrne, M.D., and A. Fitzsimmons, M.D., Milwaukee

S-26, 27 COORDINATED EXHIBIT OF STAFF OF COLUMBIA HOSPITAL, MILWAUKEE

1. CEREBRAL ARTERIOGRAPHY: David Cleveland, M.D., and S. A. Morton, M.D.
2. AORTOGRAPHY: Walter M. Kearns, M.D.
3. DISEASES OF THE CENTRAL NERVOUS SYSTEM: D. B. Claudon, M.D.
4. TUMORS OF THE THYROID GLAND: P. H. Seefeld, M.D.
5. DIAGNOSTIC TESTS FOR PAROXYSMAL NOCTURNAL HEMOGLOBINURIA: Winifred Lutsey, M. T. (ASCP)
6. TECHNIC OF THE ANTISTREPTOLYSIN TITER DETERMINATION: Marion Tully, M. T. (ASCP)
7. MILLIEQUIVALENTS IN MEDICINE: Gorton Ritchie, M.D.

This exhibit illustrates a number of the diagnostic procedures carried out in various departments of Columbia Hospital.

S-28, 29 CANCER RESEARCH AT THE McARDLE MEMORIAL LABORATORY

McArdle Memorial Laboratory and the Cancer Research Hospital, University of Wisconsin Medical School (Sponsored by the Wisconsin Division, American Cancer Society)

The exhibit will describe some of the current problems being studied at the McArdle Memorial Laboratory and at the Cancer Research Hospital, in terms of the technical operations involved and the fundamental questions that are being considered.

S-30, 31 DIAGNOSIS OF LEUKEMIA

Anthony V. Pisciotta, M.D., and Estelle M. Downer, Marquette University School of Medicine, Milwaukee County General Hospital, and the Milwaukee Division, American Cancer Society

The clinical and morphologic aspects of leukemia are illustrated by 8 by 11 enlargements of 35 mm. Kodachrome slides. Emphasis is placed upon the diagnostic aspects of the disease. Physical signs such as lymphadenopathy and splenomegaly are dealt with in one series of prints. The blood and bone marrow picture of all types of leukemia is illustrated by photomicrographs of Wright-Giemsa stained smears. Included in the demonstration are special stains, such as peroxidase stains; the India-ink phagocytic test; and the appearance of cells using supra-vital phase-contrast technic.

Two microscopes will be set up, with examples of the peripheral blood and bone marrow appearance of the various types of leukemia. In addition, the phase contrast microscope will be demonstrated.

S-33 CARDIO-VASCULAR HAZARDS IN BILIARY TRACT SURGERY

John Flinn, M.D., and John Steeper, M.D., Jackson Clinic, Madison

The exhibit will consist of a graphic demonstration of the results of a study of approximately 350 consecutive surgical procedures performed on the biliary tract, specifically emphasizing the cardiovascular complications and hazards. In addition, a series of electrocardiographs, which were taken in the operating room during biliary surgery, will be shown. The electrocardiographic results of distention of the gallbladder, clamping of the cystic duct, and dilatation of the common duct and sphincter will be demonstrated.

S-34, 35 THE USE OF THE CARDIOSCOPE

Wisconsin Heart Association

The Wisconsin Heart Association display will have an electronic cardioscope, a teaching device which was presented to Marquette and Wisconsin medical schools. It reproduces heart sounds through stethophones and projects the sounds on a cathode ray tube. Electrocardiograms can also be projected on the screen. A live subject or tape recordings can be used for the sound and picture.

Medical information produced by the Heart Association will be available to the spectators.

The background panels will describe: 1. the cardioscope, 2. the lay education program of the Heart Association, 3. professional education, 4. research, 5. community service programs, 6. finances of the Heart Association.

S-36 AORTOGRAPHY IN PERIPHERAL VASCULAR DISEASE

James M. Sullivan, M.D., Robert Frisch, M.D., and T. J. Pfeffer M.D., VA Hospital, Wood

This exhibit will consist of case reports in which aortography has been used diagnostically together with a reproduction of the individual aortograph. The various case reports will be in a separate brochure and the reproduction of the aortograph may be viewed in conjunction with this brochure. The technic of aortography will be described and illustrated as will also be the indications for this procedure particularly as related to peripheral vascular disease.

S-37, 38 ROUTINE HOSPITAL X-RAY ADMISSIONS: MINI AND LARGE FILMS

Wisconsin Anti-Tuberculosis Association

EXHIBITS FACING STAGE AND ON STAGE

-14a SPINAL CORD TUMORS

-20a Henry M. Suckle, M.D., Madison General Hospital, Madison (Exhibit located near center of hall, at end of S-14 and S-20, facing the stage)

The exhibit is to indicate the diagnosis, both clinical and myelographic, of spinal cord tumors; the surgical treatment; and also the various histologic types.

On Stage ACETABULAR PROSTHESIS

Near Fracture Demonstration) Frederick G. Gaenslen, M.D., and Herman C. Schumm, M.D., Milwaukee

The exhibit of the acetabular prosthesis demonstrates the use of a new type of prosthesis designed to mimic the acetabulum. It was designed specifically with the treatment of a heretofore unsolved problem: namely, central protrusion of the acetabulum. It has been used in two cases of this type and some of the complications encountered are illustrated.

The prosthesis is also adaptable for use in cases of fracture of the acetabulum and arthroplasty of the hip besides the use for which it was originally designed.

GENERAL NOTICES

CERTIFIED GUESTS: Medical students and hospital personnel admitted on Wednesday, *if previously certified*, or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies admitted by presenting their membership cards.

DELINQUENT MEMBERS OR NON-MEMBERS: Admitted by payment of $10.00, which will be refunded if full dues are paid through county medical society within six months following Annual Meeting.

VA AND MD'S IN MILITARY SERVICE: Members of Veterans Administration must be full dues-paying members to be admitted. Those physicians in armed services admitted by presenting certification of current military service.

RESERVATIONS FOR ROUND TABLES AND DINNER: Reservations for round tables and dinner at registration desk in Milwaukee Auditorium from 8:00-11:00 a.m. Between 11:30 a.m. and 12:15 p.m. each day reservations can be made in fifth floor foyer of Hotel Schroeder.

If you have left your dinner and luncheon tickets at home, duplicates can be secured at locations noted above. *No one may attend a luncheon or the Annual Dinner without a ticket.*

MEDICAL GOLF TOURNAMENT: The annual Medical Golf Tournament will be held at the North Hills Country Club, Milwaukee, on Monday, October 5. Tee-off time will be at 1:00 p.m., and dinner and presentation of awards at 7:30 p.m. If you have not already made reservation for this event and wish to participate please contact Mr. A. H. Luthmers at the Medical Society of Milwaukee County, Bankers Bldg., Milwaukee.

Your Reservation Order—MAIL NOW!

FILL OUT AND MAIL WITH YOUR CHECK TO STATE MEDICAL SOCIETY OF WISCONSIN, BOX 1109, MADISON.

ATTENDANCE LIMITED, SO LIST ALTERNATE CHOICES OF LUNCHEONS ON DAYS YOU WILL ATTEND. DINNER LIMIT IS 500.

LUNCHEONS—$2.50 EACH

Tuesday, Oct. 6

LEADER'S NAME

First Choice: _____

Second Choice: _____

Third Choice: _____

Wednesday, Oct. 7

LEADER'S NAME

First Choice: _____

Second Choice: _____

Third Choice: _____

Thursday, Oct. 8

LEADER'S NAME

First Choice: _____

Second Choice: _____

Third Choice: _____

DINNER ★ DANCE ★ FLOOR SHOW
($5.00 PER PERSON—400 LIMIT)

WEDNESDAY, OCT. 7—HOTEL SCHROEDER

(Includes President's Reception)

Reserve _____ places for me at the Dinner, Wednesday, Oct. 7. (Include payment with your check.)

ART DINNER ★ RECEPTION ★ PROGRAM
($4.00 PER PERSON—300 LIMIT)

TUESDAY, OCT. 6—MILWAUKEE ART INSTITUTE, HOTEL PFISTER

Reserve _____ places for me at Dinner and Reception in connection with Art Show. (Include payment with your check.)

NAME _____

(Print Please)

ADDRESS _____

CITY _____

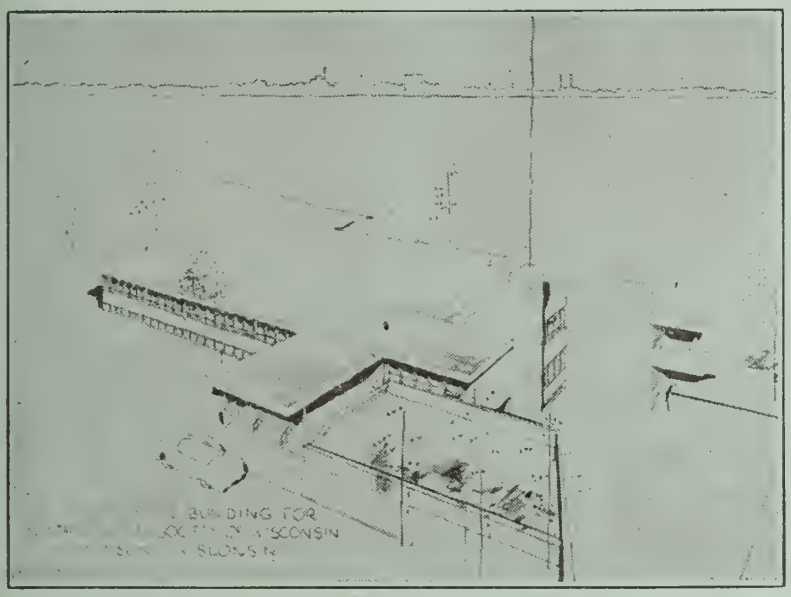
The Technical Exhibits—1953 Annual Meeting

The Technical Exhibits are important to the Annual Meeting, both educationally and financially. If it were not for their support we would have to charge each person attending a fee of around $10.00. The technical exhibitors also provide an opportunity to catch up on the latest products available for office and hospital practice. We have planned the program so that times are available for visits to the exhibits. We will appreciate your active interest in this important feature of our Annual Meeting program.

Booth	*Company*
37	Abbott Laboratories
54	A. S. Aloe Company
17	Encyclopedia Americana
73	American Hospital Supply Corporation
68	Ames Company, Inc.
66	Ayerst, McKenna & Harrison, Ltd.
75	Baby Development Clinic
55	The Baker Laboratories, Inc.
32	Barr X-Ray Company, Inc.
74	Beech-Nut Packing Company, Inc.
45	N. P. Benson Optical Company
S-7	House of Bidwell, Inc.
67	Bilhuber–Knoll Corporation
38	The Borden Company
46	Brooks Appliance Company
56, 76	Brown & Williamson Tobacco Corporation
39	Burroughs Wellcome & Co., Inc.
24, 25	Camel Cigarettes
71	Carnation Company
58	Ciba Pharmaceutical Products, Inc.
SS-2	Coca–Cola Bottling Co.
S-6	Contour Chair Company
SS-5	Fellows Medical Mfg. Co., Inc.
8	H. G. Fischer & Co.
72	C. B. Fleet Company, Inc.
1	General Electric Company
40	Gerber Products Company
S-4	H. J. Heinz Company
70	Hoffmann–La Roche Inc.
33, 34	Hurley X-Ray Company
29, 30	Karrer Company
4	Kremers–Urban Company
S-2, S-3	Laabs, Incorporated
28	Lakeside Laboratories, Inc.
64	Langer Laboratories, Inc.
69	Lederle Laboratories
44	Eli Lilly and Company
42	J. B. Lippincott Company
21	Lov-é Brassiere Company
35	M & R Laboratories
18	Maico of Madison
26	Mead Johnson & Company
13	Medco Products Company
6	The Medical Protective Company
23	Medico–Mart, Inc.
65	The Wm. S. Merrell Company
19	Miller Surgical
SS-3	The Milwaukee Company
50	V. Mueller & Company
20	The National Drug Company
11	A. R. Nechin Company
27	John Nichols, Inc.
49	Parke, Davis & Company
12	H. E. Pengelly X-Ray Company
48	Pet Milk Company
31	Chas. Pfizer & Co., Inc.
3	Philip Morris and Company, Ltd., Inc.
62, 63	Physicians & Hospitals Supply Co.
16	Professional Business Service
53	A. H. Robins Company, Inc.
43	Roemer Drug Company
14	J. B. Roerig and Company
S-1	Rystan Company, Inc.
52	Sandoz Pharmaceuticals
57	W. B. Saunders Company
9	Schering Corporation
10	G. D. Searle & Company
60	Sharp & Dohme
5	Smith, Kline & French Laboratories
51	E. R. Squibb & Sons
61	The Upjohn Company
41	U. S. Standard Products Company
7	U. S. Vitamin Corporation
22	Vaisey Bristol Shoe Company, Inc.
47	Varick Pharmacal Company
SS-1	Walden Industries, Inc.
SS-4	Warner–Chilcott Laboratories
15	Westinghouse Electric Corporation
2	White Laboratories, Inc.
36	Winthrop–Stearns Inc.
S-5	Wyeth Laboratories
59	Zimmer Manufacturing Company

THE MEDICAL FORUM

COUNCIL APPROVES CONSTRUCTION OF NEW SMS BUILDING



PROPOSED NEW BUILDING OF STATE MEDICAL SOCIETY

Present Facilities Are Outgrown; New Site on Lake Monona

Madison, Aug. 3.—The Council of the State Medical Society has unanimously approved proposals for a building project to house the Society's general offices and related activities.

The growth of medical society activities, including the expansion of Wisconsin Physicians Service, the Blue Shield plan, has increased the space requirements and facility needs beyond the capacity of the present building at 704 E. Gorham Street.

The decision to construct a new building was made upon the recommendation of the House Planning Committee consisting of Dr. E. M. Dessloch, Prairie du Chien; and Drs. N. A. Hill and H. K. Tenney, Madison.

The new building, illustrated in the architects drawing at the left, will be constructed on Society-owned property on the south shore of Lake Monona. The present offices are located on Lake Mendota.

Total cost of the new structure is estimated at $415,000. The building will be constructed, owned and operated through a State Medical Society Realty Corporation. This will permit a more effective mechanism for charging rent, maintaining the building and retiring the indebtedness in such a way that the other assets of the Society and Wisconsin Physicians Service are not involved in building operation and liabilities.

No part of the Society's membership dues will be devoted to the initial cost of the building, except as there may be some reserve available.

Actual construction of the new facilities will not begin until the Council has been able to develop adequate financing. However, the architect was authorized to proceed with the preparation of detailed specifications.

(Continued on page 464)

STATE LEVEL PLANS FOR CIVIL DEFENSE MOVE FORWARD; MANUALS DISTRIBUTED

Madison, July 28.—Though activities in perfecting organization and training of the 100 medical teams have been quiescent for a number of months, planning on the state level has been moving steadily forward. County medical societies are actively participating in recruitment and selection of team captains where there have been changes. The red covered manual for mobile medical team personnel is completed and is now being distributed.

Dr. Carl N. Neupert, medical director of state civil defense efforts, stresses that there can be no let-down now that there is an armistice in Korea. "Those who know say the chief threat is no less imminent than it was—that it is more so," said Dr. Neupert. "The doctors have never failed to do more than their part. We can't do less now."

The control center at the Capitol has had its first Command Post Exercise to learn how to alert and correlate medical teams, supplies, transportation and the like. It showed what kinks needed straightening out.

Blood procurement for first aid casualty stations (emergency needs) and for the longer-pull needs in hospitals to which casualties will be evacuated is well along as to the setting up of a standard operating procedure.

Dried plasma for these stations has been purchased in quantity sufficient to meet needs until federal stockpiles can be obtained. Federal stockpiles of plasma are building up.

The most urgent problem is that of filling the ranks of vacancies in team captain and other team personnel so that they will be ready to do trial runs and be on a "standby basis" by January 1, 1954.

Before then, all details as to operation, supplies, communication and transportation are expected to be in final form in a standard operation procedure manual so that everything that can be done to assure care to the injured in case of attack will have been done.

ROBINSON AND RASMUSEN STEER HEALTH LEGISLATION

Madison, July 20.—Two figures in the Wisconsin Legislature who have made a substantial contribution to the health and welfare of Wisconsin citizens are Senator Robert P. Robinson, Beloit and Assemblyman Holger B. Rasmusen, Spooner.

These men, respectively, head the Senate's standing committee on Education and Public Welfare and the important Welfare committee of the Assembly. Through their hands must pass virtually all the bills touching on health matters which are presented in either house.

It is incumbent upon them to exercise judgment as to which bills leave their committees with recommendation for passage by the Legislature. Since one out of every ten bills introduced has some health or welfare bearing, they have made it a point to acquire a wide variety of knowledge in the field of public health and its application in various localities.

Senator Robinson, who is serving his third term in the Senate, has been chairman of his committee since 1947. He is a lifetime resident of Beloit, having graduated from college there and taught there. Upon his return from service during World War I, he went into the advertising business, from which he is now retired. His knowledge of health and welfare problems was broadened during his active business career by extensive civic activity. He served as an alderman, a member of the school board, the Y. M. C. A. and Red Cross boards, Family Service Association and Community Chest.

ASSEMBLYMAN RASMUSEN

SENATOR ROBINSON

Assemblyman Rasmusen's background as a pharmacist has given him considerable knowledge of the medical profession and its related activities, and he has employed this knowledge constructively in dealing with health measures. He has been in the drug business since 1912 and has owned his own store since 1919. Like Senator Robinson, he saw service during the first World War, and like the Senator he is a native of Wisconsin, having been born in Superior. He was first elected to the assembly in 1949, and has been chairman of the Welfare committee for two terms.

Dartmouth Prof. Becomes Mrs. Hobby's Assistant

Washington, July 24.—Russell R. Larmon, professor of administration at Dartmouth College, has been named Assistant Secretary of Health, Education and Welfare. This is one of two Assistant Secretaries provided under Reorganization Plan 1 which elevated the former Federal Security Administration to cabinet status. Prof. Larmon has served as consultant on many state commissions in New Hampshire.

"Watch It, LIFE," Says AMA Journal Reply to Magazine Editorial Condemning AMA

Chicago, July 18.—The AMA Journal for July 18 carries an emphatic reply to an editorial entitled "Watch it, Doc," which appeared recently in *Life* magazine.

The *Life* editorial excoriated the AMA House of Delegates for approving the resolution presented to them by the Indiana State Medical Association regarding the care of crippled children.

The resolution of the Indiana association had to do with the pledge required of all Crippled Children's Diagnostic Services which receive Federal aid that the center will treat any child without charge, without restriction as to the economic status of the child's family or their legal residence, and without any requirement for the referral of the child by any individual or agency.

Indiana had adopted this pledge only under strong pressure and then lodged a protest with Washington authorities. The AMA House of Delegates backed up the Indiana association in branding this approach as being socialistic.

Life took the matter up without bothering to look into the background, according to the AMA, and without taking any note of the fact that Indiana physicians have given to crippled children's centers time that would have cost over $100,000 per year on a fee-for-service basis. *Life* also ignored the fact that Indiana was the first state to turn down welfare money from Washington.

The editorial in the AMA Journal concludes with this paragraph:

"Magazines and newspapers have ethics the same as the medical profession. In reporting on the AMA action, *Life* threw the fundamental canons of journalism —sincerity, truthfulness, and accuracy—out the window. In doing so, *Life* betrayed not only the physicians of this country but also its big family of readers. Good faith with the reader is a paramount principle. By every consideration of good faith, a magazine is constrained to be truthful. It is not to be excused for lack of thoroughness or accuracy within its control. So, in reply to *Life's* "Watch It, Doc," one can say "Watch It, *Life*."

BOTH PARTIES WORK FOR BETTERMENT OF HEALTH IN 1953 STATE LEGISLATURE

Senator Nelson is Able Advocate of Welfare, Health Measures

Madison, July 14.—When it comes to public health, party politics have no place in the Wisconsin legislature.

During the 1953 session, the law makers were confronted with many consequential issues related to public health. Dr. J. C. Griffith's "President's Page" in the July Wisconsin Medical Journal was a tribute to those legislators "whose sense of public responsibility remained steadfast in the face of relentless and almost unprecedented cultist pressure."

The modernization of the state's medical practice act, the elimination of certain barriers to the licensure of qualified physicians, and the protection of the public from cultist practices were largely the result of a bipartisan approach to public health legislation.

One of the Democratic legislators whose influence was widely felt in this field of legislation was Senator Gaylord Nelson of Madison, floor leader in 1951, and a member of the Senate Committee on Education and Public Welfare.

SENATOR NELSON

It is this committee which reviews and studies much of the important health legislation.

Senator Nelson is a native of Clear Lake in Polk County. He received his law degree from Wisconsin in 1942 and has practiced law at Madison ever since. A relative youngster in political circles, he ran for public office for the first time in 1948 and was elected to the Senate. He has rapidly gained stature in the legislature.

BEAUMONT MEMORIAL CORNERSTONE LAID ON MACKINAC ISLAND

Mackinac Island, July 19.—Dr. William Beaumont, the army doctor from old Fort Crawford, Wisconsin, was honored by Michigan physicians and public officials here last week.

Dr. Beaumont made an important contribution to medicine by his observations of the human digestive processes at work. His experiments began 131 years ago when he was able to watch the workings of the stomach of a trooper named Alex St. Martin, after St. Martin had received a shot-gun wound in the stomach. The trooper recovered, but his wound healed around a "window in his stomach" through which Dr. Beaumont was able to make his observations.

A cornerstone was placed for a memorial being built by the Michigan Medical society. Another shrine in Dr. Beaumont's honor is at Prairie du Chien.

QUACK CURE-ALLS SEIZED BY FDA

Washington, July 25.—A group of devices recently seized by the Food and Drug Administration because of false and misleading therapeutic claims included:

A voilet ray instrument said to prevent baldness, relieve pain, restore youth and vigor;

A pendulum contraption which the promoter claimed would diagnose a disease and point to "cultures" which would select a treatment from about 90 preparations (mostly herbs and vitamins);

Shoes purported to ward off and cure diseases by dispersing the electricity the body generates;

An oscillating table for weight reduction and "normalizing all body functions;"

"Radioactive pads" for the treatment of arthritis and other diseases;

Vaporizers to dispense a "cold prevention" liquid;

Ozone generators with cure-all claims.

LEGION SPONSORS NURSE'S TRAINING

Jefferson, Wis., July 15.—Jefferson County Voiture 750 of the American Legion is sponsoring a girl in nurses training, starting this coming fall.

Her tuition will be paid throughout her entire training course, and it is the hope of the voiture to make a permanent project of sponsoring a new student each fall.

The committee which made the arrangements consisted of Arnold Jorgenson, Watertown, chairman; Floyd Burhans, Jefferson and Robert Hedberg, Fort Atkinson. The project is to be known as the Nurses Training Program of the voiture.

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

COUNCIL PICKS GROUP FOR LIAISON WITH PHARMACISTS

Responsibility for Mass Polio Immunization Goes to County Societies

Madison, Aug. 3.—The Public Policy Committee of the State Medical Society has been designated as a liaison committee with representatives of the Wisconsin Pharmaceutical Association in an effort to bring about greater understanding of the drug and narcotic laws of the state and closer cooperation between the two professions.

The Council, at its meeting July 31–August 2, directed that the committee meet with the pharmacy group at its earliest convenience. The medical society and the pharmacy association have been at odds since the pharmacists took legal action to determine the right of physicians to use lay employees in the office dispensing function.

Dr. J. M. Sullivan, Milwaukee, is chairman of the Public Policy Committee. Other members are Drs. J. R. Schroder, Janesville; J. A. Enright, Milwaukee; S. E. Gavin, Fond du Lac and J. K. Curtis, Madison.

Approval of committee reports and activities occupied the Interim Committee and the Council during most of their sessions. A comprehensive report of the Commission on Prepaid Plans and an equally detailed report of the Commission on State Departments were approved for submission to the House of Delegates.

The reports will be distributed to the delegates, officers, Councilors, and county society presidents and secretaries well in advance of the meeting of the House.

County medical societies were assigned responsibility for the conduct of mass polio immunization programs in the event the disease reaches critical epidemic proportions in any section of the state. The Council directed publication of the procedures to be followed by the county societies in such cases. The details are presented on pages 471 to 473 in this issue of the Journal.

The Council also met with members of the State Board of Health to review activities and progress at the Lake Tomahawk State Camp for rehabilitation of persons who have suffered from tuberculosis.

The rehabilitation center, located near Lake Tomahawk, is under the supervision of the board of health's division on tuberculosis and is directed by Leonard Heise. It normally houses about 50 men and women between the ages of 15 and 45 whose treatment for active tuberculosis has been successfully completed. Many such persons find that the surgical and medical treatment, including years of bed confinement, have left them unsuited or untrained for any self-supporting occupation.

The camp provides an opportunity for these persons to learn new trades, resume normal social relationships, and acquire new interests and goals in life. The project is an outstanding example of cooperation between a state agency and local schools, businesses, and civic activities for the restoration of "occupationally handicapped" persons to useful and worthwhile employment.

Most of the trainees spend about 8 months at the camp. The project is entirely state-supported under the tuberculosis "free care" law and the State Department of Vocational Rehabilitation.

PUBLIC RELATIONS TIPS FOR AUGUST

Proper indoctrination of your nurses and other office assistants on the importance of good office procedure is a real step in the direction of improved public relations.

Why not hold a conference for nurses, medical secretaries, and other medical assistants?

The State Medical Society office will gladly provide assistance and leadership for such a conference. Those who participate may obtain an unusually good booklet on the subject entitled "Winning Ways With Patients."

Conferences could be held on a county-wide or city-wide level, depending on the local situation.

If you are interested, please contact the State Medical Society office, P. O. Box 1109, Madison, Wisconsin.

VA Can't Over-ride Insurance Policy "Exclusion" Clauses

Washington, D. C., July 25.—The Veterans Administration apparently is convinced the hospital insurance plans cannot be forced to drop their "exclusion clauses" which relieve the insurer of liability for payment to VA hospitals, according to the A.M.A.

Boone Writes Letter

The A.M.A. reports that the Veterans Administration position was stated in a letter by Vice Admiral Joel T. Boone, chief medical director, to a Michigan representative. Admiral Boone described various ways in which hospitalization policies were able to exclude payments to VA for non-service connected cases, and other factors that made it difficult for the agency to collect from insurers. He added:

"It is safe to say that most of the policies currently being written contain some of these or similar exclusion clauses. There is nothing illegal about this. The parties have a right to contract as they please. No state insurance commission, or other regulatory body, or governor, would have any legal authority to require such insurance companies to insure a risk they do not want to insure."

UMW to Build Hospitals for Miners in 10 Towns

Beckley, W. Va., July 11.—Construction has been started on Beckley hospital, the first of ten hospitals which are being built by the United Mine Workers Welfare and Retirement Fund in mining communities. Beckley hospital will have 200 beds, and will have a school of practical nursing.

The Washington headquarters of the organization has revealed that a contract to build 10 hospitals in Virginia, West Virginia and Kentucky has been let.

According to the Washington Report on the Medical Sciences, approximately 1000 beds will be supplied, which means the program is in the $15 million range.

THE CIVILIAN HEALTH AND MEDICAL ADVISORY COUNCIL which was appointed to assist Dr. Melvin Casberg after dissolution of the Armed Forces Medical Policy Council, was photographed at its first meeting at the Pentagon. Left to right, Dr. William S. Middleton, dean of the University of Wisconsin Medical School; Dr. Anthony J. J. Rourke, president of the Hospital Council of Greater New York; Dr Dwight L. Wilbur, Stanford University School of Medicine; Dr. Casberg, Assistant to the Secretary of Defense; Dr. Alfred R. Shands, Jr., medical director of the Nemours Foundation, Wilmington, Del.; Dr. Isidor S Ravdin, University of Pennsylvania professor of surgery and surgical research director; Dr. James P. Hollers, D. D. S., San Antonio, Tex. U. S. Army photograph.

Answers Quoted on When a Physician in Armed Services Can Resign Commission

Madison, July 20.—When may a physician commissioned in one of the armed services resign his commission? There is much confusion on this point, particularly with reference to Reservists, since the new law went into effect.

Consultation with Major C. L. Shepard, Administrative Officer of Wisconsin State Selective Service, and with Colonel Matthew B. Stockson at 5th Army Headquarters in Chicago reveals the following:

Physicians who are obligated only under the doctor draft are automatically discharged from their commissions at the end of their periods of active duty.

Reservists who would be liable for doctor draft service except for membership in a reserve unit may resign their commissions at the end of a period of active duty equal in length to the time they would have served had they been under the doctor draft.

A Reservist physician who has not had 12 months or more of active service since September, 1950, and who, because of age or prior service, was not a special registrant, may request to resign his commission—but permission may or may not be granted.

Any physician who did not register because he was already in the Reserves, and who, because of age or previous service, was not obliged to register, may resign his commission after completion of 12 months or more of active service and cannot thereafter be inducted except in time of war.

Reserve officers holding 5-year reserve commissions who are on duty under the doctor draft cannot expect their commissions to expire in the middle of an obligatory period of service under this draft. The commission is automatically renewed to the end of the period of active service.

Physicians who were less than 26 years old as of June 19, 1951, are obligated for eight years of duty in exactly the same manner as a draftee who does not come under the doctor draft. Such men must put in two years of active service and six years more with the Reserves.

Under the Public Health Service, a doctor may resign his commission at any time. However, termination of a commission must be approved by the Surgeon General if the doctor who resigns wants the time he served to be credited under the doctor draft law.

Compulsory Health Insurance in Sweden

Stockholm, Sweden, July 29.—Beginning in 1955, health insurance becomes compulsory in Sweden. The law reportedly embraces almost all Swedes, including housewives and children.

According to a report in the *Milwaukee Journal* condensed from *News from Sweden*, a publication of the American-Swedish News Exchange, Inc., the insurance program will cover 65 to 70 percent of income losses during sickness through tax free cash benefits and provide for free hospital care, as well as three-quarters of normal costs for treatment by private physicians, and free or price-reduced medicines.

The insurance program is expected to cost about 143 million dollars for the first year.

Employers will pay 27 percent by contributing the equivalent of 1.1 percent of the wages or salaries of their employees. The government will finance the remaining 29 percent.

PROFESSIONAL BUSINESS SERVICE
227 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

Regional Blood Centers To Continue Operation; Defense Centers Closed

Madison, July 30.—The closing of the Armed Forces Blood Donor Program has been announced by the American Red Cross. This will in no way effect the Badger Regional Blood Center, Dr. Merle Owen Hamel, director of the center, has announced.

The Red Cross is closing the 15 so-called "defense centers" where blood was collected solely for the armed forces. It is also cancelling contracts with various local blood centers, such as the Junior League Blood Center in Milwaukee, which have been supplying a certain quota of blood.

According to Dr. Hamel, this does not mean that all blood requirements for the military are at an end. About one million pints will be required by the Office of Defense Mobilization for the coming year, to fill needs for civil defense, the armed forces and gamma globulin production.

The regional centers, which collect blood for civilian usage and keep hospitals supplied, will be expected to supply this million pints. Their operation will be continued just as it was before the cessation of hostilities in Korea.

WATA Offers Fellowship for Graduate Training in Public Health Field

Milwaukee, July 10.—The Wisconsin Anti-Tuberculosis Association is offering a fellowship for graduate training in public health education for the school year September, 1953 through August, 1954.

The grant will consist of $1,200 to be paid in two equal installments, the first in September and the second in February. This fellowship is offered for study at one of the schools of public health accredited by the American Public Health Association. These schools include Harvard, Yale, Columbia and the universities of California, Michigan, Minnesota and North Carolina.

This grant will be made for work leading either to the degree of Master of Public Health or to other masters' degrees in public health education. It is to be made to someone who has the express intention of entering tuberculosis association employment or related public health work. If granted to a Wisconsin person, that person will be obligated to return to Wisconsin to work for at least one year.

Acceptance by a school of public health is necessary before application for a fellowship can be made, so all applicants should apply at once to several schools, in case the school of choice has a waiting list. Further information can be obtained from Miss Elizabeth L. Ryan, Wisconsin Anti-Tuberculosis Association, Milwaukee.

THE STATE BOARD OF MEDICAL EXAMINERS was photographed at its first quarterly meeting held in Milwaukee in mid-July. Asterisks* denote newly appointed members of the board. Front row, left to right, Dr. J. W. Prentice, Ashland; E. C. Murphy, D. O.; Dr. T. W. Tormey, Jr.*, Madison; Dr. Millard Tufts*, Milwaukee and Dr. C. A. Olson*, Baldwin. Back row, left to right, Dr. A. G. Koehler, Oshkosh; Dr. John A. Schindler*, Monroe and Dr. J. W. McRoberts*, Sheboygan.

WOMAN IS FINED FOR SALE OF PILLS

Jefferson, Wis., July 25.—Mrs. Martha Spoehr, Hubbleton, was fined $100 and costs in Jefferson County Court this week for selling soda pills as a cure-all remedy.

Mrs. Spoehr pleaded guilty to a charge of treating sickness without a license or certificate of registration. The pills were supposed to cure a variety of ills, and it was reported that Mrs. Spoehr was charging 85 cents a box for them.

Blue Shield Donates For Long Illness Study

Madison, July 14.—The State Medical Society's Blue Shield Plan has donated $250 to the Research Council for Economic Security. This grant is to be used for the council's study on prolonged non-occupational illness among employed persons.

This survey is being conducted to show the leading causes of absences from industry of more than four consecutive weeks duration. About 400,000 employees are to be surveyed. They represent all types of industry, plants of various sizes, all the nine census regions and metropolitan, urban and semi-rural communities.

COUNCIL APPROVES . . .

(Continued from page 459)

In its report, the House Planning Committee stated that even present activities are inadequately housed. It pointed out that the activities of the Society have increased in direct proportion to the new responsibilities that medicine has acquired in the field of social and economic relations with the public.

Forum Feature

Doctors Concerned

TEACHERS MAY FACE DAMAGE SUITS IN INJURY CASES

Madison, July 20.—The "craziest liability award" described in the Milwaukee Journal editorial at the right presents a situation of more than comic interest. The circumstances related in this case—known in legal parlance as "Heiden v. Milwaukee, 226 Wis. 92 at 97"—may quite possibly be repeated elsewhere.

Although the unfortunate verdict in Milwaukee against the chemistry teacher was reversed in circuit court, the precedent prompted introduction of legislation in the 1953 session to provide that school districts should be liable for the acts of negligence of their teachers and employees while performing duties in the scope of their employment. The bill gave the school district or city authority to carry such liability insurance.

The bill passed the Assembly but was killed by the Senate in the closing hours of the session.

Parents, Teachers Worry

Parents, teachers, and physicians around the state have evidenced concern over the liability of teachers in situations similar to the Heiden case. The matter appears now to be headed for study by the Division on School Health of the Commission on State Departments and possibly for discussion at future school health conferences.

In light of the court's decision, there is anxiety as to what might happen if, for example, a child with epilepsy had an attack at the time he happened to be on the top of a jungle gym or some other high apparatus in the school yard.

Who is responsible, for example, when a foreign body is accidentally thrown into a child's eye while he is operating a lathe in the manual arts department?

In the past, units of municipal government have not been liable for the negligence of their officers, agents, or servants, while acting in a governmental capacity or in the discharge of a governmental function. It is well established that in conducting a public school, the municipality is performing a public duty and acting in a governmental capacity.

However, this immunity has been whittled down so far as the municipality is concerned by the so-called Safe Place statute. Teachers do not enjoy the immunity of their employers and are liable for injuries to others arising out of their negligence in accordance with the rules of law relating to negligence. Until legislation provides protection, teachers will have to rely primarily on sympathetic juries and courts for relief from damage suits in the event children are injured in school.

CRAZIEST LIABILITY AWARD YET

It may seem silly that at least one Milwaukee public school should have stopped its midmorning milk program for fear of damage suits against teachers if pupils should be injured while distributing the bottles. But the fear is a perfectly understandable one in view of the absurd lengths to which juries increasingly go in assigning liability.

An outstanding case last month precipitated the issue. A teacher had assigned some boys to clean out a storage room. They roughhoused instead, a bottle of acid was knocked from a shelf, and a boy was burned. The teacher had previously warned his classes about the acid, and it was in a normally safe place. He had to supervise boys in two other rooms at the same time. Nevertheless a jury found him 55% negligent and ordered him to pay the boy's parents $412.50.

In many other cases—more and more often, it seems—juries let their sympathy for somebody who has been hurt run away with their judgment. For a prime example, a farmer, ignoring all safety instructions, stuck his arm in a hay baler and naturally got hurt. A jury awarded him damages against the manufacturer! It took the state supreme court to reverse this stupid interpretation of liability.

Now the school board is considering a request for legislation that will authorize it to carry liability insurance for teachers. This should not be necessary, if juries and courts will come to their senses. But unless some such protection is afforded, many teachers will be reluctant to assume responsibility for any activity—even classroom decoration or a museum trip.

After all, a child might be hurt and the teacher might be stuck for damages despite all reasonable care. This could stifle much that is good and important in the educational program.

In many other fields, the fear of being victimized by emotional juries, if the pattern persists, can be a deadening influence. No quick and easy remedy suggests itself. Perhaps judges in their instructions could warn more sternly against whimsical verdicts. Perhaps the law could set narrower limits on the discretion of juries to assign liability.

Best remedy, hardest to achieve, would be for jurors to stop and think, when they are asked to find somebody negligent, whether they would feel blameworthy if they were the defendant—and give a lot more thought to the consequences of handing down fancy awards just because the defendant can pay—or the jurors think he can . . .**From the Milwaukee Journal, February 8, 1953.**

First Patients Admitted to New Clinical Center

Washington, July 6.—The first 25 patients have now been admitted to the new 14-story, $62 million Clinical Center of National Institutes of Health in Washington. The building has a 500 bed capacity, but is expected to house not more than half that number by next June.

Fewer Students Applying For Admission to Medical Schools Than in Past Years

Chicago, July 16.—Continuing a three-year trend, the number of students applying for admission to the nation's medical schools declined again this year, according to the official study of 1952–53 applicants made by John M. Stalnaker, director of studies for the Association of American Medical Colleges.

Fewer Last Fall

Results of the study show that 3,150 fewer students applied for admission last fall than in the fall of 1951. There were 7,600 fewer applicants last fall than three years ago.

This trend is reflected in Wisconsin's two medical schools. Marquette had 975 applications for last fall as against 1,234 in 1951 and 1,351 in 1950. They can accept a class of slightly more than 100 freshman medical students. However the figure jumps up a little for applicants to be admitted in the fall of 1953, since 1,029 applications have been received.

Wisconsinites Preferred

The University of Wisconsin received 157 applications for admission last fall, 162 for 1951 and only 145 in 1950. Applications for next fall number 130. Wisconsin accepts a freshman class of 80 to 84 students. Their number of applications falls far below those of Marquette because, being a state institution, they do not consider applications from out-of-state premedical students except in the case of those with exceptional scholastic records. They never have more than 5 per cent of out-of-state students, and most applications arriving from outside Wisconsin are returned with a note to that effect.

The national survey shows that geographical distribution of applicants is uneven, with half of them coming from seven heavily populated states.

It also shows that the average pre-medical student applies to three or four medical schools, so that no school can expect to have every student they select. One cautious student this year applied to 45 medical schools, and was accepted by one.

HARVEY V. HIGLEY

Eisenhower Announces Marinette Industrialist Higley to be VA Chief

Washington, July 24.—Harvey V. Higley, Marinette industrialist, has been named head of the Veterans Administration by President Eisenhower. He succeeds Carl R. Gray, Jr. who recently resigned.

Mr. Higley has been active in American Legion affairs for many years. He has been state commander and a member of the Legion's National Executive Committee and National Retirement Committee. He is chairman of the board of Ansul Chemical Company.

Admiral Joel T. Boone will continue as Chief Medical Director of VA.

Bill Would Abolish Inability-To-Pay Oath

Washington, July 6.—A bill which would abolish the inability-to-pay oath which non-service-connected cases must sign before admission to a veterans' hospital has been introduced by Rep. Olin Teague (D., Texas).

Teague's bill, HR 6015, would require the Veterans Administrator to screen every application as to financial resources and as to health insurance of any kind. It sets up a priority system under which preference is given to veterans suffering from long term and chronic illnesses.

Capitol PR Meeting Wins Newsweek Praise

Madison, July 22.—An enthusiastic report of how the AMA and the state and county medical societies are helping to eliminate patients' complaints about physicians appeared in Newsweek.

The story grew out of Newsweek coverage of a seminar on the subject "Patients are People" which was staged by the Medical Society of the District of Columbia for physicians' office aids.

According to the story, patients' complaints usually center around the same few things. They don't like to be kept waiting too long. They consider many doctors too cold and impersonal and they are often resentful in regard to medical fees. The story spoke highly of the placques in many doctors' offices which invite patients to discuss the matter of fees.

The story quoted Dr. Josephine Renshaw who urged that patients be greeted cheerfully in the outer office, and that the patient's name be frequently and correctly used by the doctor during interviews. She urged physicians to keep appointments as promptly as possible.

The meeting was also addressed by John C. Post of Professional Business Services who said that kindness, tact and the prompt rendering of a bill helped the doctor to collect. "Immediately following treatment, the patient sincerely intends to pay," he stated. "Once he gets well, his interest in paying tends to wane." He urged doctors to be tactful but firm in regard to their collections, saying that to abandon delinquent accounts is unfair to the 90 per cent of patients who conscientiously pay their bills.

BRAZILIAN WITH U. S. TRAINING W.H.O. HEAD

Geneva, Switzerland, July 21.—Dr. M. G. Candau has succeeded Dr. Brock Chisholm as Director-General of the World Health Organization.

Dr. Candau is a native of Brazil who received his medical training in his own country and his public health training at Johns Hopkins University.

He joined WHO in Geneva in 1950 as Director of the Division of Organization of Health Services.

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

PRESENTATION OF CASE*

The patient, a 17 year old white female high school student, was admitted because of swelling of the face and neck, accompanied by fever. The swelling was noted about five days before and at that time was not painful. She subsequently felt some malaise and was sleepy. On the day of admission to the hospital her temperature was 104.4 F. The swelling involved the eyelids (which were at first swollen nearly shut), cheeks, and the back of the neck. The neck subsequently became somewhat painful. The patient felt dizzy when bending over. The day before admission to the hospital she had received a dose of penicillin, after which her hands and feet felt numb and tingling.

History by systems added little information. She had no cough, chest pain, or gastrointestinal or urinary tract difficulty. There was no nausea or vomiting. Her menstrual periods were irregular and menstrual flow was heavy; and in the previous three months she had fainted on two or three occasions during her menstrual periods. She had been treated for dysmenorrhea, and had been placed on a diet by her physician, after which she lost 18 lb. In the recent past she had had several sore throats, frequent colds, and occasional "dry scaly" skin rashes on becoming excited. The patient stated that she had used a new type of detergent shampoo for the first time two or three days before the onset of her illness. She said she did not eat raw meat except for frankfurters, which she had had about two weeks before.

Past history included the usual childhood diseases—measles, chickenpox, scarlet fever, and whooping cough.

Physical Examination. She was obviously feverish; the skin was flushed and dry. There was swelling about the face and soreness over the mastoids and neck. No muscle pain or tenderness was elicited. The pulse was 108, respirations 22, blood pressure 130/72. Despite her high temperature she did not appear or act very ill. She was rational and cooperative. There was no lymphadenopathy, neck rigidity, or pharyngeal inflammation. There was some postnasal drip. The chest was clear to auscultation and percussion and the heart was not enlarged. There was a soft systolic blow at the apex and aortic area. Her abdomen was soft and was somewhat tender in the left upper quadrant, where there was a questionably palpable spleen.

A blood count on admission showed a hemoglobin of 12.5 Gm., red blood cell count of 4,160,000, and white blood cell count of 13,800 with the following differential: stabs 5 per cent, segmented 61, eosinophils 20, lymphocytes 12, and monocytes 2. The urine had a specific gravity of 1.018 and was negative for albumin, sugar, and cellular elements. An x-ray examination of the chest showed no abnormalities. An intravenous pyelogram was likewise within normal limits.

Laboratory studies included the following negatives: tuberculin skin test; Trichinella skin test; agglutinations for typhoid, paratyphoid, brucellosis, and typhus; heterophil antibody test; and blood culture. Cerebrospinal fluid: cell count 0, sugar 63, protein 24, colloidal gold 0 throughout. Repeated blood counts showed a minimum red blood cell count of 3,800,000 and hemoglobin 12 Gm. The white blood cell count increased to a maximum of 25,000, subsiding to 9,000 before the patient left the hospital. Differential counts showed variations in eosinophil and stab percentages. The eosinophilia decreased from its maximum on admission of 20 per cent to a final 6 per cent. Stab forms increased to 29 per cent by the fifth hospital day and then subsequently diminished to a normal level. Sedimentation rate was 45 mm. in one hour. Urine had a trace of albumin on a single occasion; a few leukocytes and erythrocytes per high power field were found in several specimens. There were no casts. Specific gravity of the urine varied from 1.018 to 1.010. A bone marrow aspiration showed a myeloid hyperplasia with eosinophilic proliferation. Most of the myeloid elements were relatively mature.

* From the Departments of Pathology, St. Mary's Hospital, Racine, and Marquette University School of Medicine, Milwaukee; **Dr. C. R. Newman**, clinician; and **Dr. Myron Schuster**, pathologist.

Treatment consisted of aureomycin, penicillin, aspirin, and tepid sponges for fever.

The patient showed no immediate response to treatment and continued to run an intermittent fever, reaching a maximum of 105.4 F. The fever then began to diminish in severity and after the eighth hospital day was generally about 99 F., ultimately tapering off to normal.

Despite the high spiking temperature, the patient generally felt well and had few complaints except for some minor soreness in the neck. The edema of the face soon subsided and the patient was discharged in an afebrile condition on the fifteenth hospital day.

Dr. Myron Schuster: Doctor Newman has consented to discuss the differential diagnosis of this interesting clinical problem for us today.

Dr. C. R. Newman: One's attention is immediately directed toward the cause of a febrile illness, the prominent features of which are leukocytosis with eosinophilia, localized edema, and some muscle pain, in this case confined to the neck area.

Certain febrile illnesses are rather readily ruled out as not characteristically exhibiting eosinophilia. Others occasionally associated with eosinophilia, such as scarlet fever, chorea, postfebrile pneumonia, measles, chickenpox, rheumatic fever, and malaria, are not seriously considered here on the basis of the previous history, the lack of characteristic findings, and the course of the disease.

Consideration of an allergic etiology might lead one to suspect a reaction in the facial skin to the detergent shampoo used two to three days before admission. However, the eosinophilia which might result from such a reaction would probably not be as high as 20 per cent nor would the systemic reaction be as great as in this patient. A reaction to penicillin would usually occur earlier than 7 to 10 days after administration and would tend to give more of a generalized urticarial reaction. In addition there is no indication of an allergic diathesis in this patient's history.

Little support can be found for the diagnosis of certain other disease states. Löffler's syndrome may be ruled out on the absence of chest symptoms and signs and the presence of a negative chest x-ray. Fifteen to twenty per cent of cases of periarteritis nodosa in the acute phase may have a significant eosinophilia; however, the course of this illness and the absence of signs of hemorrhage or interference with blood supply in various organs make this diagnosis unlikely.

Characteristics of several skin diseases sometimes associated with eosinophilia are lacking. These diseases include pemphigus, erythema multiforme, scabies, herpes zoster, psoriasis, and eczema. The diagnosis of familial eosinophilia and tropical eosinophilia are unlikely on a statistical basis alone.

High eosinophil counts may be found in diseases of the hematopoietic system, including myelocytic leukemia, eosinophilic leukemia, and pernicious anemia, all of which are rather readily disposed of by the study of the bone marrow and the findings in the blood. Absence of lymphadenopathy both on physical examination and chest x-ray does not support the diagnosis of Hodgkin's disease.

The peculiar localized edema mentioned in the protocol as well as the rather limited muscle pain points rather strongly toward Trichinella infestation as the cause of the patient's symptoms. No support is found for any other cause of the edema, either on an acute inflammatory, cardiac, or renal basis. Teen-aged eating habits predispose to certain infestations, being introduced in poorly cooked meats, and in this case raw frankfurters were eaten within the time estimate for incubation of trichinosis, between 3 and 28 days. Frankfurters have been reported as definitely transporting this disease, as have other poorly cooked meats containing pork.

It seems likely that the patient was admitted to the hospital during the period of systemic invasion by the larvae. There is no history of severe gastrointestinal symptoms characteristic of the phase of localization of adult worms in the gastrointestinal tract. However, the latter is not unusual when it is remembered that there is a rather high incidence of this disease in the United States, yet most infestations are unrecognized.

One might feel that Trichinella infestation would produce more muscular pain, but this is not necessarily the case. The muscle pain depends primarily on the muscles invaded by the migrating larvae and the quantity of the larvae that enter the individual muscle groups. A single negative Trichinella skin test does not rule out this condition. Positive reactions usually occur two to three weeks after the onset of symptoms and are usually immediate and urticarial in nature later in the disease or convalescence, although it is

said that delayed reactions may occur earlier in the disease.

The leukocytosis and increased stab count are also common in this condition and usually are greatest in the second week of illness. The eosinophilia, highest here on admission, is usually greatest later in the disease.

Antibiotics used in treatment here seemed to produce no dramatic effect. The fall in temperature appears to have occurred rather gradually to normal in 8 to 10 days, which is compatible with the diagnosis of trichinosis.

Various other parasitic infestations should be considered. Those giving actual tissue invasion usually give the higher eosinophil values, such as Echinococcus, Filaria, Bilharzia, all being unlikely here. Lower eosinophil counts may be expected with infestations such as oxyuriasis, Ascaris, amebiasis, hookworm, etc., which do not invade tissue to such an extent.

For completeness, the discussion should mention certain diseases of the bone, neoplasms, endocrine disorders, irradiation, and postsplenectomy states which might give eosinophilia but which are not supported in any degree by the information supplied in the case history.

We are thus left with a diagnosis of trichinosis. Although the protocol of the clinical history makes no mention of it, a muscle biopsy in this case would seem to me to be a logical step, since the diagnosis of Trichinella infestation was apparently under consideration. I assume this information was purposely omitted to avoid exposing the diagnosis.

Doctor Schuster: Thank you, Doctor Newman. You were correct in assuming that a muscle biopsy was performed, that it settled the diagnosis, and that this information was purposely omitted to allow the discussant free rein in analyzing the differential diagnosis. We received a biopsy from the pectoralis major muscle, and prepared serial sections from it. We found a focal interstitial myositis which included moderate numbers of eosinophil leukocytes in its exudate. Individual segments of muscle fiber showed varying degrees of degenerative change ranging from loss of striations to basophilia, with associated proliferation of sarcolema nuclei. At a few points the reaction included multinucleated giant cells which were probably of muscle origin. Of course, the most outstanding feature was the presence of several parasites which were found lodged within muscle fibers, undergoing a process of encystment. These organisms, which stain in a basophilic fashion, were larval *Trichinella spiralis*, which in some sections were seen to be starting to coil in typical manner.

Trichinosis, a disease of worldwide distribution, should be more prominent clinically than it seems to be, since many surveys claim an incidence (in this country) of something like 15 to 20 per cent of the population. Obviously only a minute percentage of these are ever identified clinically. The discrepancy would appear to be based on two factors: survey technics and lack of suggestive symptomatology. Specialized procedures such as peptic digestion of autopsy specimens of diaphragm account for the reported high incidence of this disease, whereas lack of expected symptoms and a low index of diagnostic suspicion are responsible for the infrequency with which these cases are picked up in clinical practice.

In summarizing the mechanism of this disease process, it should be possible to fit the known facts of the parasite's life cycle into the patient's clinical history. Completion of the Trichinella life cycle requires two hosts, though they need not be of different species. The usual reservoir of infection is provided by the rat and pig. Man makes a trio of this partnership by eating inadequately cooked pork, whereupon the digestive process liberates the encysted larvae from the infected meat. Within a period of about a week the larvae have matured and the viviparous females are discharging new larvae into the tissues of the duodenal wall. Free transportation via lymphatics and blood stream is available, and the larvae are thus disseminated to other regions of the body, particularly to the heart, brain, and skeletal muscle. This invasion is attended by acute inflammatory reaction and toxemia. Within three weeks larvae are becoming encapsulated, and their further maturation is halted.

Classically, these phases are accompanied by more or less characteristic symptoms. Invasion of the intestinal wall results in gastrointestinal disturbances; larval migration induces pains, facial edema, fever, eosinophilia, and sometimes evidence of encephalitis or myocarditis; the constitutional effects reach

their maximum severity by the time the larvae are becoming encysted, and fatalities may occur from collapse, cardiac failure, or neurologic disorders. In the majority of infections, these symptoms are so mild (because of the relatively small number of parasites) that they do not provide the examining physician with an etiologic clue.

Fitting these features into this patient's story leaves only minor discrepancies, mainly the lack of gastrointestinal symptoms and the negative Trichinella skin test. The latter has been adequately discounted by Doctor Newman as merely indicating insufficient time for development of sensitivity to the antigen. Incidentally, the skin test was repeated after a lapse of seven days, but remained negative; the patient was requested to return in two weeks for a retest, but failed to do so. The history of eating raw pork was rather vague, since to some of the examiners she firmly denied doing so, yet, when questioned by others, thought she might have. An especially striking and puzzling feature of this case was the general sense of well-being and the minimal nature of subjective complaints despite the persistent spiking fever; under the circumstances, she might be expected to have been much sicker and less inclined to spend most of the day eating chocolate bonbons and reading movie magazines.

MARQUETTE–JACKSON CLINIC POSTGRADUATE PROGRAM
Saturday, October 3

On Saturday morning, October 3, the day of the Wisconsin–Marquette football game, the twenty-third annual postgraduate clinic presented by members of the faculty of the Marquette University School of Medicine and the staff of the Jackson Clinic will be held in the Tower of Health at the Methodist Hospital, Madison.

After the medical program presented by members of the faculty of Marquette and the staff of the Jackson Clinic, there will be a luncheon at the Loraine Hotel for the doctors and their wives.

Any physician who would like to attend the meeting and luncheon and who does not receive a reservation card may request one by writing Dr. Arnold S. Jackson, chairman.

Tickets for the Wisconsin–Marquette football game may be ordered from the Athletic Ticket Office of the University of Wisconsin.

The program is scheduled as follows:

Case Presentations — Members of the Jackson Clinic Staff

Recent Developments in the Treatment of Rheumatic Fever—Margaret Prouty, M. D.

Functional Uterine Bleeding—Lee B. Stevenson, M. D.

Illustrated Talk on Europe—Arnold S. Jackson, M. D.

Intermission

Present Concepts in the Treatment of Burns—Russell Kurten, M. D., Racine

Hypertension and Renal Failure — William L. Coffey, Jr., M. D., Milwaukee

Discussion—Francis D. Murphy, M. D., Milwaukee

The Discharging Nipple—James Garland, M. D., Milwaukee

Practical Concepts of the Rh Factor—Jack A. Klieger, M. D., Milwaukee

Luncheon at the Loraine Hotel for doctors and their wives

Football Game

Criteria for the Procurement of Gamma Globulin for Mass Immunization

Reprinted below is Gamma Globulin Letter No. 7 from the Department of Health, Education, and Welfare (Division of Civilian Health Requirements) addressed to all State and Territorial Health Officers. It is followed by a statement of the policies and recommendations established by the State Board of Health and approved by the Council of the State Medical Society on the recommendation of the Committee on Blood Banks.

This is to inform you of the criteria and procedures as promulgated by the Office of Defense Mobilization in connection with the allocation of Poliomyelitis Immune Globulin (Human) for use in the mass prophylaxis of poliomyelitis.

It is recognized that the following criteria do not cover all possible situations but it is believed they will serve as an equitable mechanism for establishing eligibility in those situations now anticipated.

Allocations for Mass Prophylaxis

1. *Criteria*

Requests for allocations for mass prophylaxis will be considered for use in specified counties, provided all of the following criteria are satisfied at a time when the trend of the weekly incidence is rising:

a. At least 5 cases must have occurred in the county between March 28, 1953, and the time of a request for additional Poliomyelitis Immune Globulin.

b. There should be at least 20 cases forecast to occur in the county during this calendar year. (See Appendix for method of making the forecast.)

c. The predicted county incidence must reach or exceed the prevailing critical poliomyelitis incidence. (See "2" below.)

2. *"Critical poliomyelitis incidence"*

The allocation of Poliomyelitis Immune Globulin for mass prophylaxis will be limited to counties reaching or exceeding a calculated *critical poliomyelitis incidence.*

The critical poliomyelitis incidence will be determined by *this office* with reference to:

a. the U. S. population under age 15;
b. forecasts of national incidence in 1953; and
c. the quantity of Poliomyelitis Immune Globulin available for mass prophylaxis purposes.

Periodic recalculations of this critical poliomyelitis incidence will be made to take into account changes both in the national poliomyelitis forecast and in the supply of Poliomyelitis Immune Globulin.

The prevailing critical poliomyelitis incidence will be provided health officers by this office at approximately biweekly intervals.

It is expected that State and Territorial Health Officers will make preliminary calculations to determine if any high incidence counties qualify for consideration to receive allocations for mass prophylaxis. This is done by comparing the critical poliomyelitis incidence with the *predicted incidence* in the county in question. The latter incidence is obtained from county morbidity data through the latest reporting week extrapolated to the end of the year in accordance with the previous seasonal pattern of poliomyelitis. The predicted incidence can be obtained by using the table (p. 472) which shows, by State, the average cumulative weekly percentage distribution of reported cases through successive weeks of the years 1948–1952. When the predicted incidence in any county reaches or exceeds the prevailing critical poliomyelitis incidence, and the criteria stated in 1a and 1b, above, are met, that county will be eligible for consideration for allocation of additional Poliomyelitis Immune Globulin. (Illustrative calculations which may simplify and clarify the techniques used are shown in the attached Appendix.)

The maximum amount of Poliomyelitis Immune Globulin which may be allocated to a county, for mass prophylaxis, will be determined as follows:

Number of children in the county under 15 years of age x 10 = cc. of Poliomyelitis Immune Globulin to be allocated. Under certain circumstances, such as inadequacy of available supply, it may be necessary to limit the quantity of Poliomyelitis Immune Globulin allocated. In such cases, the material provided might be used to best advantage by restricting it to use within selected communities in the county.

Since data for previous years are available only by counties, it is necessary to determine eligibility from *county* morbidity and population data, and it is not possible to apply these criteria to any other spatial or governmental units.

3. *Procedure for submitting requests*

As soon as any county within a State or Territory meets the criteria described, the State or Territorial Health Officer may make application for a supply of Poliomyelitis Immune Globulin for those individuals in the county who are subject to the greatest risk.

The request from the State or Territorial Health Officer should include the following information, to cover the period between March 28, 1953, and the date of the request:

a. the number of cases by *week of onset;*
b. the number of respirator cases;
c. the ratio of paralytic to total reported cases in the area; and
d. the number of deaths.

The application will be reviewed by this office. If approved, Poliomyelitis Immune Globulin (within the available supply at the time) will be provided for mass prophylaxis.

4. *Special requirements as to use and disposition of Poliomyelitis Immune Globulin*

Allocation of Poliomyelitis Immune Globulin for mass prophylaxis to any county in which the critical poliomyelitis incidence has been reached or exceeded is to be made with the following understanding:

a. The Poliomyelitis Immune Globulin will be administered to all eligible persons in the county within a period of not more than 10 days after the date on which the State or Territory has been notified of allocation.

b. All Poliomyelitis Immune Globulin not used within the period specified above will be reported promptly to the Division of Civilian Health Requirements, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C., for disposition.

APPENDIX

Annual Estimates of County Incidence (Predicted Incidence)

The following examples illustrate the mechanism of calculating a county's predicted incidence:

Example 1—A county of 60,000 population in Alabama has reported 20 cases through June 27 (25th week), of which at least 5 were reported after March 28, 1953. Since Alabama cases through the first 25 weeks of the year have constituted an average of 12.8 percent of the annual caseload (see attached table, "Cumulative Weekly Percentage Distribution of Reported Polio Cases"), divide 20 by .128 to obtain an estimate of 156 cases for the year. This number corresponds with a case rate of 260 per 100,000 population (156 divided by 60,000 times 100,000). If the prevailing critical poliomyelitis incidence has been prescribed at 16 per 100,000 for example, this county qualifies for consideration for mass prophylaxis.

Example 2—A county of 50,000 population in Maine reports 10 cases by August 22 (33rd week), at least 5 of which were reported after March 28, 1953. Divide 10 by .329 (see table) to obtain an annual estimate of 30 cases for the year. Since 30 cases represents a case rate of only 60 per 100,000, this county could not yet qualify on the basis of a prescribed critical poliomyelitis incidence of 160 per 100,000.

Example 3—A county of 8,000 population in Michigan has reported 6 cases through September 5 (35th week), at least 5 of which were reported since March 28, 1953. Divide 6 by .432 (see table) to obtain an estimate of 14 cases for the year (a case rate of 175 per 100,000). This county does not yet qualify, regardless of the critical poliomyelitis incidence prescribed, because fewer than 20 cases are estimated for the year.

POLIOMYELITIS. *Table for Predicting Annual Estimates of County Incidence—Cumulative Per Cent of Cases*

Week No.	Ending	1948–52 Average (P.H.S.)			
		Alabama	Maine	Michigan	Wisconsin
20	5–22	7.4	1.3	1.8	1.3
21	5–29	7.6	1.6	1.9	1.4
22	6– 5	8.1	1.7	1.9	1.5
23	6–12	9.0	2.2	2.1	1.7
24	6–19	10.3	2.3	2.2	1.9
25	6–26	12.8	2.6	2.5	2.3
26	7– 3	15.4	3.1	2.9	2.8
27	7–10	19.5	4.8	3.4	3.4
28	7–17	23.4	7.2	4.3	4.0
29	7–24	28.9	9.3	6.3	5.7
30	7–31	34.3	12.7	9.5	8.0
31	8– 7	39.8	15.9	13.7	11.0
32	8–14	47.2	24.7	20.0	15.6
33	8–21	53.0	32.9	27.7	21.4
34	8–28	59.4	41.3	35.3	26.4
35	9– 4	64.1	48.9	43.2	34.1
36	9–11	69.6	58.8	50.1	42.0
37	9–18	74.5	68.0	57.6	49.0
38	9–25	78.5	73.2	60.1	58.3
39	10– 2	81.7	78.7	66.3	65.5
40	10– 9	84.8	83.1	71.9	72.3
41	10–16	87.2	85.7	77.1	77.4
42	10–23	88.7	88.1	81.7	82.0
43	10–30	90.7	89.9	85.8	86.4
44	11– 6	92.5	92.2	89.2	90.0
52	———	100.0	100.0	100.0	100.0

Procedures to Be Followed in Wisconsin

In order to expedite the procurement of gamma globulin for mass immunization and the successful conduct of such a program, the State Medical Society and the State Board of Health have established the following policies and recommendations:

I. Requests for mass immunization for poliomyelitis will be processed by the State Board of Health and referred to the Division of Civilian Health Requirements only when:

A. The county medical society initiates the request.

B. The following essential information is at the same time furnished the State Board of Health:

1. number of respirator cases in the county
2. number of current deaths due to poliomyelitis in the county (This constitutes part of the information to be sent to the Division of Civilian Health Requirements)

C. The county medical society assumes full responsibility for the organization and conduct of the immunization program, and its completion within the 10 days specified by the Division of Civilian Health Requirements.

D. The county medical society arranges for the necessary equipment and supplies, other than the gamma globulin.

E. The county medical society agrees to adhere to the conditions to be met for the use of the gamma globulin as laid down by the Division

of Civilian Health Requirements of the Public Health Service with respect to:

1. age groups to be immunized
2. area to be covered (county)
3. return of unused gamma globulin
4. completion of records on use of gamma globulin

II. Final approval of requests is the responsibility of the Division of Civilian Health Requirements. Criteria established in the above letter, and the available supply, are assumed to govern the granting of approval.

III. The State Board of Health stands ready to assist the county medical society in the organization of the program within the limitations of its personnel and facilities.

(It is suggested that the District Health Officer be called upon to assist the county medical society in the calculation of the anticipated annual incidence of poliomyelitis within the county in order to determine whether the county qualifies for additional gamma globulin for mass immunization purposes from the Public Health Service.)

Note: It may be possible for the county medical society to arrange for loan of equipment such as syringes and needles, etc., from the National Foundation for Infantile Paralysis, the American National Red Cross, or the Public Health Service.

NEW LEGISLATION AFFECTING PHYSICIANS LICENSED IN SOUTH DAKOTA

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licensees in that state in the amount of $2.00. The registration takes effect January 1, 1954. If you are licensed in South Dakota and wish to maintain that license by payment of the registration fee, please contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota.

EIGHTEENTH ANNUAL CONVENTION OF THE NATIONAL GASTROENTEROLOGICAL ASSOCIATION

The National Gastroenterological Association will hold its eighteenth annual convention and scientific sessions at the Biltmore Hotel in Los Angeles on October 12, 13, 14, 1953. The program will include a Symposium on Cirrhosis of the Liver; Panel Discussions on "Peptic Ulcer"; "Diseases of the Large Bowel"; and "Latest Developments in Cancer Research". There will be additional papers on interesting subjects in gastroenterology and related fields.

Following the convention, on October 15, 16, 17, 1953, the Association's fifth annual course in postgraduate gastroenterology will be given at the Biltmore Hotel and the College of Medical Evangelists in Los Angeles. The course will be under the personal direction of Drs. Owen H. Wangensteen of Minneapolis, Minn. and I. Snapper of Chicago, Ill., who will be assisted by a faculty from the medical schools in and around Los Angeles.

The scientific sessions on October 12, 13, and 14 are open to all physicians without charge. The postgraduate course will be open only to those who have matriculated in advance. Further information concerning the program and details of the postgraduate course may be obtained by writing to the Executive Officer, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

CLINICS ON HEARING CONSERVATION IN INDUSTRY ANNOUNCED

WAUSAU
SEPT. 10

OSHKOSH
SEPT. 24

RACINE
OCT. 14

Under the Auspices of

THE WISCONSIN COUNCIL OF SAFETY

THE DIVISION ON HEARING AND VISION AND THE INDUSTRIAL HEALTH COMMITTEE, STATE MEDICAL SOCIETY OF WISCONSIN ★ INDUSTRIAL HYGIENE UNIT, STATE BOARD OF HEALTH ★ WISCONSIN MANUFACTURERS ASSOCIATION ★ INDUSTRIAL NURSES SECTION OF WISCONSIN STATE NURSES ASSOCIATION

Features of Special Interest to MDs

ON MORNING PROGRAM: "Hearing Problems in Relation to Industrial Noise Exposure"
At Wausau: Aram Glorig, M.D., Auditory & Speech Correction Center, Walter Reed General Hospital, Washington, D. C.

At Oshkosh and Racine: D. E. Wheeler, Ph.D., American Academy of Ophthalmology & Otolaryngology, Los Angeles

ON AFTERNOON PROGRAM: Panel on "Responsibilities of Physicians and Nurses in an Industrial Hearing Conservation Program"

Participants: T. L. Tolan, M.D., Meyer S. Fox, M.D., and Paul L. Whitaker, M.D., Milwaukee; and Ruth Martineau, R.N., Milwaukee

If you have any direct responsibility for advising management on industrial health programs, attendance at one of these conferences is strongly urged.

Fee: $5.00 including luncheon.

Registration: Through Wisconsin Council of Safety, State Office Building, Madison. When you register, indicate clearly which clinic you will attend.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 AUGUST 1953 Number 8

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point

R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Political Medicos

"The whole trouble with our State Medical Society is that it is run by a clique who have been in it so long that the Society can't get them out. We'll never make any progress until we get some new, and probably younger, blood on the Council and on the various committees." Many times a remark like this has been made among the members of the medical profession in the state of Wisconsin. The question is, Is it true and, if so, what's to be done about it? In an association such as ours, there are numerous positions to be filled year after year to run the Society and, though there are many competent men available for these positions, expediency and inertia tend to preserve the status quo once the positions have been filled. Then again, there are many men in office who have a sincere desire to continue to serve their fellow practitioners in these positions. There are even a few who, after holding office for a certain length of time, suspect that they are irreplaceable.

In a democratic organization such as the State Medical Society, it is this writer's feeling that the constant infusion of new blood into the various committees and Council is an absolute necessity. The more men who can be cajoled, enticed, and inveigled into serving on either the Council or some of the various committees and the more all of us take an active part in the proceedings of our Society, the better off the Society will be.

We have been particularly fortunate in having very capable men on the Council and on the various committees for the past several years—men who have done exemplary work in their positions. But many of these men have been doing their unrewarded jobs too long and should be relieved of some of these onerous tasks. The policy of returning the same councilor from the same district for years on end, it seems to me, is unfair to the district and to the councilor. The various county societies should take it upon themselves to see that these jobs are spread around a little more. No one man should serve year after year simply because he does a good job and is willing to continue. Many other members of the Society could do just as well if they would. Public relations within the society will be better served when more and more members take an active part in the affairs of the Society.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Problem Being Met

One hundred and six years ago, scattered medical societies joined together to form the American Medical Association. Their purpose was to achieve better and more uniform medical standards throughout the nation. Now the Association's membership is composed of 140,000 doctors and the scope and diversity of its work in bettering the nation's health deserves the widest possible recognition.

The Association spends $10,000,000 each year in study and research. . . . Much fine work has been done to encourage development of voluntary prepaid health insurance plans designed to take the financial shock out of sickness. . . .

It has been found that we have an unbalanced distribution of doctors rather than a shortage of them. . . . This serious problem is being resolved without violation of basic personal freedoms by physician placement services. . . . Rural communities are being encouraged to build offices or small hospitals and equip them with modern apparatus as inducements for young doctors.

The finest medical care is available to more Americans than any other people. It is reassuring to the public to see private medicine moving so rapidly and effectively to meet the medical needs of the nation.—WESTBY TIMES, June 24, 1953.

VA Hospital Abuse

This newspaper is not always in accord with the American Medical Association, but we are inclined to agree with a resolution the 185 member AMA house of delegates passed a few days ago. The resolution calls on congress to put an end to free medical care for veterans with non-service-connected ailments.

The doctors say the government should take care of non-service-connected cases of tuberculosis or neurological disorders "because of the inadequacy of local facilities designed to provide treatment for such cases.". . .

Much of the increase in VA hospitals has come from the load of non-service-connected cases, as they have mounted from 19,715 to 66,830 in the last 20 years. . . . The best possible hospitalization and care for any veteran with a service-connected or service-aggravated disability is a right that no American will question. . . .

The truly needy veteran should also be entitled to the benefits of VA hospitalization but unless some steps are taken to verify the statements of veterans who are not averse to signing what has become a winked-at formality, the non-service-connected patient load will continue to increase and the burden on the taxpayers will be ever-increasing. —RICE LAKE CHRONOTYPE, June 24, 1953.

50 Million Dollars

The spending of 50 million dollars, in the case of Wisconsin Blue Cross, has called for a celebration. For it means that since this voluntary hospital prepayment plan was established 13 years ago it has paid that much in hospital bills for Wisconsin subscribers in their time of need. . . .

It has strengthened the voluntary, non-profit hospitals of the state by reducing their collection problems. It has helped prevent a good many patients, no doubt, from becoming public charges in case of illness, thereby lessening the load on the tax supported hospitals.

Wisconsin Blue Cross has a long way to go yet . . . but the coverage can be made as complete as any subscriber will need.—MILWAUKEE JOURNAL, June 24, 1953.

Solving Our Problems

The basic medical care problems of small communities can be solved without turning to the government to pay the bills and give the orders. That fact was stressed at the recent Council on Rural Health of the AMA.

The prime requisite, as one speaker phrased it, "seems to have been imagination and leadership." Another said that one point uppermost in rural health planning has been that "there was to be no Santa Claus in the picture."

A successful community health program demands the cooperation of all concerned. Doctors are attracted to localities, even very small ones, where the residents are actively out to promote better health and are working to provide the necessary facilities and opportunities. — SHAWANO EVENING LEADER, June 12, 1953.

535 North Dearborn Street, Chicago 10, Illinois
ERICAN MEDICAL ASSOCIATION news notes
AMA news written especially for use in state medical journals
AUGUST 1953

Additional Standards for Medical Record Technicians

Essentials for the training of medical record librarians were established in 1943 by the AMA's Council on Medical Education and Hospitals, in cooperation with the American Association of Medical Record Librarians. As sufficient personnel is not available in this field, additional standards have been prepared for the training of medical record technicians who, working under the supervision of a qualified medical record librarian or medical record committee, perform the technical tasks associated with the maintenance of medical records. Temporary approval of this program was given by the House of Delegates at its June 1953 session to facilitate the establishment of new schools in September.

These new essentials provide for the training of high school graduates who are given nine months of instruction in anatomy, medical terminology, secretarial practice, and medical record procedures. Acceptable courses may be conducted by general hospitals having a minimum of 4,000 annual admissions, adequate teaching material, and personnel. At the present time there are 24 schools approved for the training of medical record librarians who receive one year of hospital training after completion of two years of college or graduation from an accredited school of nursing. Applications for approval should be submitted to the Council on Medical Education and Hospitals, 535 North Dearborn Street, Chicago 10, Ill.

America's Doctors Give to Medical Education

More than one million dollars has been donated to medical education by physicians in the United States since the first of the year. Reports released by the American Medical Education Foundation indicate that approximately 11,000 physicians have contributed $800,000 to the Foundation since January 1. At the same time, records from 33 of the nation's 79 accredited medical schools show that 8,217 doctors have contributed $301,426.42 directly to their alumni organizations. These figures indicate that 9.9 per cent of the nation's physicians have given in excess of one million dollars this year to help alleviate the financial stress in medical education today.

New Exhibits Ready for Showings

With county fair time just around the corner, the AMA's Bureau of Exhibits announces the completion of two new exhibits . . . one on nutrition and the other a portable version of "Health Today," the popular display showing that the American people enjoy better health today than ever before.

Theme of the nutrition exhibit points up the fact that a variety of foods in the daily diet are required to maintain sound health. Premiere showing will be at the American Dietetic Association national meeting August 25–28 in California.

The portable "Health Today" exhibit includes all of the features of the heavier one but can be shown at a lower cost. It was designed primarily to fill a need in parts of the country where shipments of heavier displays deterred borrowing any at all. This exhibit occupies a space 10 feet long, and the user must supply banquet-type tables and his own illumination.

Bookings may be arranged through the Bureau.

SAMA Girds for Big Year

There's a big year ahead for the Student American Medical Association . . . Two resolutions passed at the June national convention indicate its expanding field of interest not only in the medical student but also in the intern and pre-medical student. To acquaint members with the various features of the National Intern Matching Plan, Inc., one resolution called for a special committee to prepare a report on the Plan for publication in the SAMA Journal. Another resolution encourages local chapters to set up high school advisory committees to counsel pre-medical students.

Three new chapters were admitted to the SAMA roster, bringing the total number of chapters to 63. The new groups are located at the University of Utah, Woman's Medical College of Pennsylvania, and State University of New York College of Medicine at New York City, Brooklyn.

Officers installed for the ensuing year include—John H. Caskey, Baylor University College of Medicine, president; David J. LaFond, Marquette University School of Medicine, vice-president; Russell F. Staudacher, Chicago, executive secretary; and Daniel Heffernan, Wayne University College of Medicine, treasurer.

Members of the new executive council include—Robert P. Crouch, Bowman–Gray School of Medicine of Wake Forest College; Donald E. Harrop, University of Pennsylvania School of Medicine; Leland W. Hoar, University of Oregon Medical School; Clifton F. Mountain, Boston University School of Medicine; Stephan J. Plank, University of California School of Medicine at San Francisco; Patricia J. Stuff, Woman's Medical College of Pennsylvania; and Clifford G. Vernick, Tufts College Medical School.

. . . . THE PRESIDENT'S PAGE . . . .

A "New" Annual Meeting

NO OTHER scientific session in Wisconsin quite compares with the Annual Meeting of the State Medical Society. As I read through the program outlined in this issue of the *Journal*, I couldn't help but reflect on the tremendous opportunity it offers the physicians of this state. Here, during three days, is concentrated a unique array of distinguished and gifted men, many of whom are our own Wisconsin colleagues and a surprising number of whom are out-of-state guest speakers of national and international repute.

I am particularly pleased that we will have Doctor J. B. Brown of St. Louis with us for a discussion on homografts. His experience should be most valuable. Doctor Friedberg of New York, discussing the heart, will interest every general man. You will want to attend a special program on medicine and psychiatry which teams Dean John Hirschboeck with David Boyd of Rochester and Joseph C. Aub of Boston. De Coursey, who is Director of the Armed Forces Institute of Pathology, brings back some interesting experience from studies in Hiroshima on tissue reaction to ionizing radiation. Neither the pediatrician nor the general man should miss Milton Senn's discussion of emotional problems of children. Certainly of interest to Wisconsin physicians, in light of recent legislation permitting the marriage of epileptics, will be O. P. Kimball's talk and round tables on epilepsy in relation to inheritance.

The man who can't be away from his practice for more than a day should find the new dates most helpful. The scientific sessions run Tuesday, Wednesday, and Thursday, October 6–7–8. The House of Delegates starts on Monday, and, incidentally features a visit with the AMA's forceful and dynamic President McCormick. I am anxious to hear his comments on *Life* magazine's recent blast on medicine as well as his views on other problems such as grievances, legislation, and public relations.

Every doctor in Wisconsin ought to take time out for a study of "The Story of Medicine in Art." This exhibit of medicine from the earliest times is presented especially for doctors at the Milwaukee Art Institute. It portrays health progress in paintings, drawings, sculpture, coins, stamps, pharmaceutical paraphernalia, letters, manuscripts, and books. Never before has such an exhibit been assembled in America. The Medical Society can be proud of its sponsorship in cooperation with the Art Institute and a Milwaukee department store.

The lighter vein is supplied at the annual dinner. A full evening of pure enjoyment—"no windy speeches"—is promised for all who like to combine music, eating, dancing, and floor shows of professional caliber.

I hope that I can encourage every physician in Wisconsin to spend at least one or more days at the October Annual Meeting. My enthusiasm for this meeting is exceeded only by my conviction that your attendance will be rewarded by personal enjoyment and enrichment and by higher professional achievement.

J. C. Griffith M.D.

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Compli-cations[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. Searle & Co.
P. O. Box 5110, Chicago 80, Illinois

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Blue Shield "Change-Over" Completed

All Blue Shield subscribers now hold either "A" or "B" coverage under the new program.

A year ago Wisconsin Physicians Service began the major task of converting more than 2,600 groups and thousands of non-group subscribers from coverage under an obsolete benefit program to the new "A" and "B" schedules. The change involved not only contract provisions but higher costs and new sales policies. Halfway through the conversion, Blue Cross increased its rates, with the effect that subscribers absorbed two price increases in six months. With maximum effort this sales force, through Blue Cross, completed the conversion last month.

Not only did the majority of old subscribers continue their coverage under the change-over program, but some 20,000 persons have been brought into the "A" and "B" plans as new subscribers. About 35 per cent of Blue Shield subscribers have the "A" coverage.

The implication of the new program for physicians is demonstrated in a brief analysis of the operations of Blue Shield during the fiscal year which ended June 30, 1953.

During these twelve months, almost $1,250,000 in benefits was paid under the new "A" and "B" program. The total benefits paid last year, under both the old and new schedules, was almost $2,500,000.

More than 2,200 Wisconsin doctors are participating physicians in the Blue Shield plan. What this means to the participating physician is clearly evident in the fact that 78 per cent ($1,980,000) was paid directly to them for services rendered to Blue Shield subscribers and their dependents last year. A total of $550,000 was paid directly to subscribers for services rendered by non-participating physicians.

The volume of payments to physicians for their services is rapidly increasing. In 1951 Blue Shield paid out about $1,600,000 in claims. It is estimated that 1953 payments will exceed $3,000,000. Some indication of this trend is found in a report that benefit payments of $300,000, $325,000, and $320,000 have been made during the months of April, May, and June 1953 respectively — nearly $1,000,000 in three months.

If this trend continues, payments for 1953 will exceed the cost of services rendered in 1952 by over $1,000,000 and will be more than double the experience during 1951. Approximately 82 per cent of these payments will go to group subscribers. Another 12 per cent will go to former group subscribers now holding conversion contracts. The remaining 6 per cent in benefits will be provided for non-group members.

Significantly, women accounted for more than ½ the payments in the last fiscal year. Services performed for them accounted for over 55 per cent of the total claims payments of $2,500,000. Dependent children accounted for 22.2 per cent and men for 22.4 per cent of the dollars paid out in claims.

Obstetrical benefits were the largest single "dollar item" in the procedures paid last year. They accounted for more than $400,000 in claims payments. The second highest claims payments went for medical care, nearly $375,000. Other high payment items were appendectomies, $162,000; T & A's, $145,000; and home and office surgery, $106,000.

A comparison of the incidence of procedures during the past year with those provided during the previous year shows significant changes in medical care, anesthesia, and x-ray benefits. The decided increase in medical care incidence was due primarily to the expansion of this benefit under the new program to provide coverage during the first three days of hospitalization. Part of the increase may have resulted from increased use of hospital facilities, especially that occasioned by the expansion of hospital building programs during recent years. Both anesthesia and x-ray benefits showed a substantial increase, primarily because many of the "obsolete" contracts excluded not only medical care but also anesthesia and x-ray benefits. At the present time, all contracts outstanding have been converted to the new program and include both anesthesia and x-ray at improved benefit schedules.

Improved Opportunities To Serve You

In keeping with the progress of Milwaukee and of Wisconsin, the House of Bidwell, Inc., manufacturers of prosthetic, orthopedic, and surgical appliances, proudly announces the moving of their Milwaukee facilities to their beautiful new building at 535 N. 27th Street. This completely modern building will house the most up-to-date facilities in the Middle West, all designed with the patient in mind.

Founded in 1936 by the late G. L. Bidwell, the House of Bidwell has grown from its original staff of five members to a total of twenty-four, which includes our branch office at 520 S. Park Street, Madison, Wisconsin, under the management of Robert N. Bidwell. The Milwaukee office is headed by Richard G. Bidwell.

One important improvement at our new location is the addition of ample parking facilities. The building has been designed so that patients will have no steps to climb at any entrance. Located on U. S. Highway 41, our new location is easily accessible by automobile; patients who use public transportation will have only a half block to walk from the Michigan Street busline.

We believe we have fulfilled the dream of our founder, G. L. Bidwell, to whose memory our building is respectfully dedicated.

house of BIDWELL inc.

ORTHOPEDIC, PROSTHETIC & SURGICAL APPLIANCES

535 N. 27th St., Milwaukee 8, Wis. **520 N. Park St., Madison, Wis.**

COMMITTEE *Concentrates*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS
JUNE 14

MDs present: T. L. Squier (chairman), A. H. Heidner, N. O. Becker, J. W. Boren, Jr., A. P. Zlatnik, W. S. Middleton, J. S. Hirschboeck.

The Committee discussed the IBM punch card system which is being developed to record pertinent information concerning Wisconsin physicians; offered suggestions as to type of information to be included and recommended that such statistical surveys be conducted every year for the first five, and thereafter biennially . . . reviewed the placement service of SMS, conducted for the benefit of physicians desiring to locate in Wisconsin and of communities and individuals seeking physicians; recommended that the project be continued and that communities seeking physicians be requested to offer information as to special projects or contributions designed to attract physicians and assure community cooperation . . . voted to engage in three pilot studies covering distribution, adequacy, and availability of physicians in practice and to make a detailed study of a community already successful in securing medical assistance . . . approved a recommendation to prepare a brochure for interested physicians detailing medical and other facilities of the state as a whole . . . discussed the preceptorship system in Wisconsin, its purpose and history; agreed that it is a closely integrated part of medical education under the supervision and responsibility of the medical schools, that the Society should not be in a position to control or supervise, but can endorse and assure cooperation, that expansion is entirely a prerogative of medical educators.

COORDINATING COMMITTEE ON POSTGRADUATE EDUCATION
JUNE 18

MDs present: J. W. Gale (chairman), P. A. Midelfart, Robert Parkin, George Collentine, Jr., Raymond Rice, R. P. Welbourne, A. A. Pleyte, Milton Feig, Donald Ausman, Douglas Vollan (A.M.A. Council on Medical Service and Hospitals).

The 1953 clinic program was reviewed, and initial plans were made for circuit programs in March, April, May, and June of 1954. Winter months will be omitted because of uncertain weather conditions. The Committee discussed with Doctor Vollan of the American Medical Association certain types of programs carried on successfully in other states. In addition to the basic circuit programs recommended, the Committee formulated plans for a series of Hearing Conservation Clinics in September and October 1953 and a series of Cancer Clinical Conferences during the last week in October 1953; approved a series of meetings on Mental Deficiency, in cooperation with the Division on Mental Hygiene of the Department of Public Welfare; and authorized the Wisconsin Anti-Tuberculosis Association, the two divisions of the American Cancer Society, and the Wisconsin Heart Association to develop a series of one-day conferences on "Diseases of the Chest" for either 1954 or 1955.

COMMISSION ON PREPAID PLANS
JUNE 20–21

MDs present: E. M. Dessloch (chairman), Robert Krohn, N. A. Hill, J. T. Sprague, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, R. M. Moore, Richard Foregger, G. W. Carlson, W. T. Casper, R. C. Parkin; and C. R. Pearson, J. J. Rouse, J. S. Hess, E. G. Nafziger, J. H. Houghton, guests.

Approved experimental community enrollment program . . . requested staff to submit definite proposal on catastrophic insurance for early Commission consideration and subsequent Council approval . . . reviewed latest WPS financial reports . . . approved participation in national Blue Shield–Blue Cross advertising program . . . directed distribution of bulletins of Wisconsin Plan participating companies . . . set fees for Porro cesarean section of $225 "A" schedule, $175 "B" schedule . . . medical care not included in total limitations stated in formulas for multiple and multiple-stage (surgical) procedures.

COUNCIL ON MEDICAL SERVICE
JUNE 28

MDs present: D. E. Dorchester (chairman), R. L. MacCornack, D. N. Goldstein, D. M. Willison, J. S. Devitt, W. J. Fencil, C. G. Reznichek, L. O. Simenstad.

The Council recommended establishment of a tape-recording loan service of March of Medicine programs for a trial period of one year . . . approved the appointments to Doctor Devitt's nursing education committee and asked that information and suggestions be sent to Doctor Devitt . . . reviewed tentative table of contents for proposed

manual on medical-press relations . . . heard general discussion of plans for joint meeting of Rural Health Conference and Wisconsin Public Health Council to be held in Madison, November 4–5 . . . held a discussion with Gordon Crump, editor of the Cambridge *News*, and Carl Zielke and William Sumner of the Wisconsin Press Association about community health problems and how the weekly press might work more closely with the medical profession toward the achievement of better health . . . requested chairman to appoint a subcommittee to work with Wisconsin Press Association . . . recommended that the society devote its efforts to supporting safety programs, rather than conducting an accident survey . . . recommended that the State Medical Society expand its health education activities to include television showings of films approved by AMA and State Board of Health . . . suggested that the staff continue to try to obtain replies from all county societies regarding emergency medical service . . . requested that a resolution be introduced at the House of Delegates making it mandatory for hospital staffs to set up an emergency mechanism in areas where no such arrangement exists . . . discussed proposal that Wisconsin state highway maps include a symbol identifying location of all general hospitals in Wisconsin.

CLAIMS COMMITTEE
JUNE 29

MDs present: C. G. Reznichek, J. T. Sprague, N. A. Hill, R. C. Parkin.

The purpose of the meeting was to discuss and settle some WPS problem cases.

DIVISION ON GERIATRICS
JULY 9

MDs present: John Schindler (chairman), A. M. Hutter, M. T. Morrison, E. H. Jorris.

The discussion was directed to projects which should concern the Division on Geriatrics of the Commission on State Departments. Representatives of the State Board of Health and the Department of Public Welfare reviewed programs of special concern to the Division, and recommended the preparation of a guide for county societies and other groups immediately concerned with the establishment of facilities for the aging population. Discussion was also directed to the development of public forums on the subject, and the possibility of developing an institute at the University of Wisconsin on various problems related to the aged. The Division has recommended that such public meetings and institutes be developed under the auspices of the Council on Medical Service and Public Relations.

GRIEVANCE COMMITTEE
JULY 9

MDs present: R. E. Fitzgerald (chairman), E. W. Mason, E. D. Sorenson, C. E. Zellmer, F. A. Nause, H. W. Wirka.

Representatives from the New York State Medical Society and its group malpractice insurance carrier were present to discuss their program. Study of such a program for Wisconsin has been assigned to this committee.

POSTGRADUATE COURSE ON OBSTETRICS TO BE PRESENTED BY U. W.

A postgraduate course in obstetrics will be given at the University of Wisconsin Medical School, Tuesday through Thursday, Sept. 1–3.

Dr. John W. Harris, professor of obstetrics and gynecology, will direct the course. Dr. Curtis J. Lund, chairman of the department of obstetrics and gynecology at Rochester University, New York, will serve as guest lecturer.

Members of the Medical School staff who will also assist in instruction include Drs. Ralph E. Campbell, John E. Gonce Jr., Carl S. Harper, Chester M. Kurtz, and Madeline J. Thornton.

The three-day school will include lectures, clinics, and question periods. Registrants will be urged to bring up problem cases from their own practices for discussion by the faculty.

Registration is limited to 40 doctors. Application for enrollment may be made through Dr. Robert C. Parkin, co-ordinator of graduate medical education, University of Wisconsin Medical School, Madison.

Society Proceedings

Ashland–Bayfield–Iron

Dr. R. E. Burns, Madison physician, was the guest speaker at the May 20 meeting of the Ashland–Bayfield–Iron County Medical Society, held at the Menard Hotel in Ashland. The title of the doctor's talk was "Diagnosis and Treatment of Intervertebral Disks." After the showing of a film, the members present participated in a general discussion on the subject.

Crawford

Meeting at the Hotel San in Prairie du Chien on July 15, members of the Crawford County Medical Society heard a talk by Mr. Myron S. Burton on raising funds for a Community hospital. Also present to address the physicians was a representative of Blue Shield–Blue Cross, who spoke on the possibility of a community enrollment program.

Green Lake–Waushara

The Wisconsin Heart Association held a Rheumatic Fever Clinic at the June 24 meeting of the Green Lake–Waushara County Medical Society. *Drs. M. J. Lustok* and *Jules Chase*, both of Milwaukee, examined patients referred by local physicians and made recommendations for follow-up treatment.

Kenosha

Thirty-three members of the Kenosha County Medical Society gathered at Brittle's Restaurant, Kenosha, on June 4 to hear an address by Commander John Seale, U.S.N. Commander Seale, who is associated with the Fourth Naval Medical Research Unit at Great Lakes, Ill., discussed "Poliomyelitis and Its Treatment with Gamma Globulin."

Marinette–Florence

"Medical Economics" was the title of a talk presented by *Dr. Joseph C. Griffith*, Milwaukee, at the June 17 meeting of the Marinette–Florence and Menominee (Mich.) County Medical Societies. Doctor Griffith is president of the State Medical Society of Wisconsin.

Trempealeau–Jackson–Buffalo

The June 9 meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held at the Mondovi Hotel. The subject chosen for discussion during the scientific portion of the meeting was "Anemia."

When the Society met at the Club Midway near Independence on July 14, the subjects discussed were "Uterine Cancer" and "Care of Rheumatic Fever."

Winnebago

Dr. John T. Petersik, superintendent of the Winnebago State Hospital, was the speaker at the May 28 meeting of the Winnebago County Medical Society, held at the Hotel Athearn in Appleton. Doctor Petersik illustrated his talk with movies taken at the Hospital.

Wisconsin Society of Pathologists

The following resolution was passed by the Wisconsin Society of Pathologists and the Section on Pathology of the State Medical Society of Wisconsin on November 29, 1952, and approved by the Council of the State Medical Society at its May 23 and 24, 1953, meeting:

WHEREAS, under the provisions of Public Law 779, 81st Congress (Doctor Draft Law), members

THE MARY POGUE SCHOOL

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

Catalogue on request.

G. H. MARQUARDT, M. D.
Medical Director

BARCLAY J. MACGREGOR
Registrar

32 Geneva Road, Wheaton, Ill. (Near Chicago)

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY-MANSFIELD DIVISION

of the Wisconsin Society of Pathologists and/or of the Section of Pathology of the State of Wisconsin Medical Society may be called to duty with the U.S. Armed Forces, and

WHEREAS, these physicians may be associated with institutions under conditions in which the re-employment provisions of the Universal Military Training Act as governed by U. S. Code Title 50, Section 459 may not be operative, and

WHEREAS, the loss of such association, by the physician upon return from Armed Forces service through the employment of a second physician by the institution during such period of service, would be unfair to the physician, NOW, THEREFORE, BE IT

RESOLVED, That the members of the Wisconsin Society of Pathologists and/or the Section on Pathology of the State of Wisconsin Medical Society pledge jointly and to each other

1. To respect the temporarily vacant position of a fellow member on military leave of absence, and
2. To jointly provide such professional service as may be required by the institution during such period of absence; AND BE IT FURTHER

RESOLVED, that this resolution be forwarded with a recommendation for parallel action to the organized radiologists and psychiatrists in the State of Wisconsin and to the State of Wisconsin Medical Society for approval and publication.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met in Manitowoc on May 23 and 24. The scientific program included talks by Dr. Fred Z. Havens, Rochester, Minn., "Tumors of the Larynx and Comments on Vocal Cord Paralysis"; Dr. John B. Erich, Rochester, Minn., "Fractures of the Jaw, Nasal and Malar Bones—Management of Fractures and of Associated Soft Tissue Injuries"; and Dr. Peter C. Kronfeld, Chicago, Ill., "Present Trends in Ophthalmological Thinking." Other features of the meeting included golf, a tour of the S. S. John J. Boland at the Manitowoc Ship Yards, and a business meeting.

NEWS ITEMS AND PERSONALS

Elcho Holds "Dr. Dailey Day"

The biggest celebration in Elcho's history took place on Saturday, June 6, when over 700 people turned out to pay tribute to *Dr. Paul J. Dailey*, who has a record of 40 years of medical practice in Elcho. Sponsored by the American Legion auxiliary, "Dr. Dailey Day" fell on the physician's 65th birthday, and included a parade, a picnic, a baseball game between the Elcho Cardinals and Doctor Dailey's babies, and a dinner at the Muskie Inn Hotel.

A native of Birnamwood, Doctor Dailey graduated from Marquette University School of Medicine in 1913 and set up practice in Elcho on August 9 of that year. Active in the civic and business life of the community, Doctor Dailey served for 27 years as president of the school board and has been president of the Elcho State Bank since 1938. He is the town's health officer.

The happiest moment in Doctor Dailey's career? "It was the day my son Dee joined me in practice," he reports. Doctor Dee, a graduate of Loyola University School of Medicine in Chicago, returned to Elcho in 1946 to work with his father.

Tomah Has New Doctor

Dr. C. E. Kozarek of the Kozarek Clinic in Tomah recently announced that *Dr. R. G. Konicek* had become associated with him in the practice of medicine.

Doctor Konicek received his degree from Marquette University School of Medicine after an interruption of two years for service in the Navy. He served a year's rotating internship at Milwaukee County General Hospital and then practiced for a year with the Prairie du Chien Clinic.

Dr. S. C. Myers Opens Office

Dr. C. Y. Wiswell has announced that he has been joined in practice in Williams Bay by Dr. Sherman C. Myers, who occupies an office adjacent to Doctor Wiswell's. Doctor Myers, a graduate of the Western Reserve University School of Medicine, was released from the Navy in July 1952 after nearly three years on duty in Japan and Korea.

Russell Joins Sheboygan Clinic

Dr. John H. Russell has become associated with *Dr. E. G. Schott* at the Sheboygan Clinic. An eye, ear, nose, and throat specialist, Doctor Russell's work will include plastic surgery of the ear, nose, and throat and broncho-esophagology. Though Doctor Schott will continue to handle ear, nose, and throat cases, Doctor Russell's help will give him more time for eye surgery and treatment.

A native of Tarrytown, N. Y., Doctor Russell is a graduate of the University of Virginia Department of Medicine and served his internship at Milwaukee County General Hospital. From 1950 until his appointment to the Sheboygan Clinic, he was a resi-

ACCIDENT • HOSPITAL • SICKNESS
INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building **Omaha 2, Nebraska**

$200,000.00 deposited with State of Nebraska for protection of our members

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue — MILWAUKEE, WISCONSIN — *Phone:* WOodruff 4-0900

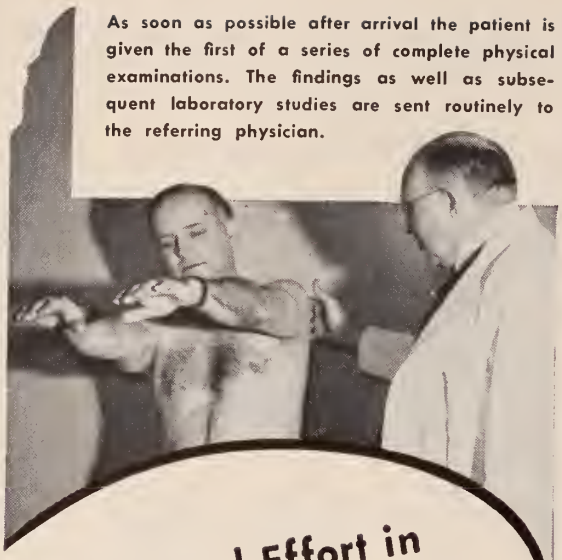
For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899



As soon as possible after arrival the patient is given the first of a series of complete physical examinations. The findings as well as subsequent laboratory studies are sent routinely to the referring physician.

Coordinated Effort in
TREATING the
ALCOHOLIC
PATIENT

The system of therapy at The Keeley Institute is aimed (1) at overcoming the *acute attack* of alcoholism; restoring the patient's well-being, and (2) through group and individual re-education attaining a condition of *permanent sobriety*.

At all times the regimen of treatment is well coordinated under the direction of a staff of experienced full-time physicians who are members of the American Medical Association.

When you refer a patient to The Keeley Institute, you know that he will be taken care of as your patient and you are continually informed of his progress.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

dent surgeon in ear, nose, and throat at the Veterans Administration Hospital in Wood. He is a member of the Milwaukee County Oto-Ophthalmic Society.

Doctor Miale Takes Miami Post

J. B. MIALE, M. D.

Dr. John B. Miale, pathologist and director of laboratories for the Marshfield Clinic and St. Joseph's Hospital, Marshfield, since 1946, has been appointed professor of clinical pathology at the recently founded Miama (Fla.) Medical School and will also serve as clinical pathologist at Jackson Memorial Hospital (University Hospital). He and his family will leave for Miami late this summer.

A native of Rochester, N. Y., Doctor Miale graduated from the University of Rochester School of Medicine in 1940 and served his internship at Strong Memorial Hospital in Rochester. Since that time he has taught in the medical schools at Rochester, Cornell, and North Carolina and has served as pathologist at Brady Urological Institute, New York Hospital; Watts Hospital, Durham, N. C.; and at the Marshfield Clinic and St. Joseph's Hospital. Under his direction the laboratory at St. Joseph's Hospital has grown from two rooms with three workers to a modern 10-room department with 10 technicians, and the laboratory has been expanded to include several new diagnostic procedures.

In 1951 he receive the annual Sheard–Sanford award of $5,000 from the American Society of Clinical Pathologists for a paper entitled "The Role of Coagulase–Globulin in Normal and Abnormal Blood Coagulation."

Doctor Bartos Answers Cancer Questions

Dr. Joseph A. Bartos of Waukesha answered questions on cancer at two meetings sponsored by the Waukesha Woman's Club in conjunction with the American Cancer Society. Held in Waukesha's Pix Theater on the mornings of March 19 and 20, the meetings featured six films on the subject of cancer.

Dr. C. S. Youngstrom Moves to Manitowoc

After four years of practice in Vinton, Iowa, Dr. Clarence S. Youngstrom has moved to Manitowoc, where he will be associated with *Dr. L. W. Gregory* of the Gregory–Simenson Clinic. A graduate of the University of Nebraska College of Medicine, Doctor Youngstrom specializes in surgery and gynecology.

Dr. Irving V. Grannis Retires

After almost 40 years of service to Menomonie and Dunn County as an eye, ear, and nose specialist, *Dr. Irving V. Grannis* has announced his retirement because of ill health. His part-time replacement is *Dr. T. W. Dasler* of Eau Claire, who will spend one full day and two half days in the office formerly occupied by Doctor Grannis.

Son of the late Dr. E. H. Grannis, who practiced in Menomonie from 1877 to 1916, the younger Doctor Grannis was born on July 30, 1882. After his graduation from Harvard Medical School in 1914, he joined his father in practice until the latter's death in 1916. On the completion of around two years of army service in World War I, he returned to Menomonie and resumed his solo practice. He was on the staff of the Menomonie Clinic.

Doctor Dasler, a graduate of the University of Wisconsin Medical School, spent three years as an associate of *Dr. W. B. Cornwall* in Amery and Deer Park before entering the Navy in 1941. During his six years of naval service, he served for 20 months on a destroyer in the Pacific, underwent a period of training at the U. S. Naval Hospital in Idaho and at an eastern hospital corps executive school, and was named senior medical officer on a new cruiser. He was discharged as a commander.

At Northwestern University and Veterans Administration Hospital in Hines, Ill., he completed the requirements of the American Board of Ophthalmology. He will continue to maintain the office he opened in Eau Claire in 1952.

Dr. R. G. Welsch Opens Kenosha Office

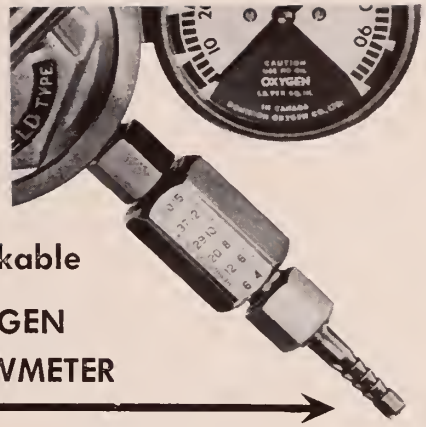
On July 1, at the completion of a residency at Milwaukee County General Hospital, *Dr. R. G. Welsch* opened an office in Kenosha for the practice of pediatrics. A graduate of St. Louis University School of Medicine, Doctor Welsch served for five years with the U. S. Navy Medical Corps and spent five years in general practice in Sheboygan Falls before going to Milwaukee.

Podruch Reports for Military Duty

A Wausau physician for nearly three years, *Dr. P. E. Podruch* has reported to Fort Sam Houston, San Antonio, Texas, for active duty with the Army Medical Corps. Doctor Podruch is a graduate of Marquette University School of Medicine and practiced at Barron before moving to Wausau.

Dr. R. P. Froeschle Leaves Sparta

Returning to the area in which he and his wife grew up, *Dr. R. P. Froeschle* has left Sparta to set up practice in western North Dakota. He has been associated with the Sparta Clinic since last year He is a graduate of the University of Illinois and interned at Milwaukee County General Hospital.



an unbreakable OXYGEN FLOWMETER

for emergency use

The "Linde" Liter Flow Adaptor and a face mask, carried in the physician's car, can "save the day" in a respiratory emergency when a standard therapy regulator is not available. Connected to an industrial oxygen cylinder and regulator, used in repair shops, factories, and on many farms, the Adaptor makes possible safe, accurate oxygen administration.

This emergency oxygen flowmeter is small and contains no glass or moving parts.

available from any of these distributors of

Linde OXYGEN U.S.P.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding and Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS
LITER FLOW ADAPTORS • OXYGEN THERAPY
ADMINISTERING EQUIPMENT

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

Meyer Honored as Oldest Doctor

The oldest doctor in Juneau County, Dr. Herman C. Meyer, was honored during Necedah's centennial celebration over the Fourth of July week end. Doctor Meyer came to Necedah in October 1919, as a temporary replacement for the community's Doctor Parham, who was too ill to carry on his practice. On Doctor Parham's death, Doctor Meyer stayed on—and has practiced in Necedah ever since.

A native of Oshkosh, Doctor Meyer did not start out to be a doctor. After attending Oshkosh State Teachers College, he taught science for three years in the high schools of Drummond, Brillion, and Menasha. Turning to medicine, he took a premedical course at the University of Wisconsin, graduating with honors in 1915. He completed his medical training in 1917 at Rush Medical College in Chicago. It was after two years in the Army Medical Corps during World War I that he came to Necedah.

In addition to his private practice, Doctor Meyer is the town's health officer and a director of the Necedah Bank.

Doctor Maresh Talks on TB

Dr. Frank Maresh, staff physician of the State Sanitarium near Milwaukee, spoke on the study and treatment of tuberculosis at St. Joseph's Hospital in Hillsboro, June 9. Doctor Maresh's talk, based on his four years in Alaska, was accompanied by slides.

Doctor Holmes Leaves for Military Service

Dr. C. L. Holmes, a member of the staffs of the Marshfield Clinic and St. Joseph's Hospital, Marshfield, for the past two years, has reported for duty at Fort Sam Houston in San Antonio, Texas. After a six weeks' course in a medical service school, he will be assigned to a permanent station in the Army, which he is entering with the rank of captain.

A graduate of the University of Tennessee College of Medicine, Doctor Holmes served his internship at Baptist Memorial Hospital in Memphis. After six months as a general practitioner in Kentucky, he was awarded a fellowship in surgery at the Mayo Clinic, where he studied from 1943 to 1948. Before coming to Marshfield in 1951, he practiced general and chest surgery in Boise, Idaho, for three years.

Doctor Holmes is a fellow of the American College of Surgeons and the American College of Chest Physicians and is certified by the American Board of Surgery and the American Board of Thoracic Surgery.

La Crosse Clinic Has New Home

The staff of the La Crosse Clinic are now at work in their new quarters on South Eleventh Street. After extensive interior remodeling, the former

In very special cases
A very superior Brandy

Specify 84 PROOF

★ ★ ★

HENNESSY

THE WORLD'S PREFERRED
COGNAC BRANDY

For a beautifully illustrated book on the story of Hennessy, write—

Schieffelin & Co., Dept. HT, 30 Cooper Square, N.Y. 54

ROEMERS—MILWAUKEE

Surgical Supplies
Hospital Supplies
Office Furniture
Laboratory Supplies

* * *

Complete Service to the Medical Profession

* * *

Roemer Drug Company
606 No. Broadway
Milwaukee 2, Wisconsin

Fantle Home is now equipped to do work in x-ray, physiotherapy, electrocardiography, and minor surgery.

Members of the staff include *Drs. Joseph E. Egan* and *James P. Pauly*, obstetrics and gynecology; *Dr. G. I. Uhrich*, general surgery; *Dr. Gregory J. Egan, Jr.*, pediatrics; Drs. A. W. Hickey and *Robert E. McMahon*, internal medicine; and *Dr. James C. Fox*, general practice and internal medicine.

Three other staff members are on temporary leave of absence. *Drs. Paul W. Phillips* and *Charles M. Kelly, Jr.*, are currently serving in the Navy. *Dr. B. J. Mansheim*, now completing special training in diseases of the eye, will rejoin the staff on November 1.

Matthiesen Recalled to Service

Dr. Don E. Matthiesen, formerly of Lancaster, has been recalled to active duty in the Navy and is now stationed at the U. S. Naval Hospital in Jacksonville, Fla., in the department of radiology.

At the April meeting of the American Board of Radiology, held in Tampa, Fla., Doctor Matthiesen was granted a certificate in radiology.

Doctor Brown Joins Midelfart Clinic

On July 1 *Dr. Richard C. Brown*, a specialist in obstetrics and gynecology, joined the staff of the Midelfart Clinic in Eau Claire. For the past three years Doctor Brown has been at the Milwaukee Hospital and also held an appointment as assistant clinical instructor in obstetrics and gynecology at Marquette University School of Medicine. A 1949 graduate of the University of Pennsylvania School of Medicine, Doctor Brown served his internship at the University hospital there.

Rowe Replaces Heinz at Kohler Co.

On the departure of *Dr. H. N. Heinz* for military service, Dr. Donald M. Rowe has joined the medical department of the Kohler Company in association with *Dr. C. C. Gascoigne*. A 1951 graduate of the Marquette University School of Medicine, Doctor Rowe interned at St. Joseph's Hospital in Milwaukee and served a residency in internal medicine at Veterans Administration Hospital in Wood. For the past year he has been associated with *Dr. A. J. Verdona* in Milwaukee and was district physician for the Milwaukee Health Department.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Puestow Attends Meeting

Dr. Karver L. Puestow, professor of clinical medicine at the University of Wisconsin Medical School, attended the meeting of the American Therapeutic Society from May 28 to 31. He has been elected a member of the council of the Society.

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director

Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

Dr. G. A. Berglund Opens Office

Dr. George A. Berglund has opened an office for the practice of neurology and neurological surgery in Madison. A 1942 graduate of the University of Oregon Medical School, Doctor Berglund served a residency in neurosurgery at Wisconsin General Hospital and was previously associated with *Dr. Henry M. Suckle* of Madison.

Rock

At the May meeting of the Rock County Medical Society *Dr. Sture A. M. Johnson* spoke on "Tumors of the Skin." Doctor Johnson is a professor of dermatology at the University of Wisconsin Medical School.

Milwaukee Oto–Ophthalmic Society

In lieu of the May meeting of the Milwaukee Oto-Ophthalmic Society, a scientific program by the department of otolaryngology of the University of Chicago was presented at Milwaukee's University Club. Officers for 1953–54, approved by mail ballot, are *Dr. Gerhard D. Straus*, president; *Dr. Erwin E. Grossman*, vice president; and *Dr. Donald T. Hughson*, secretary-treasurer. Serving on the board of directors with Doctor Straus are *Drs. B. P. Churchill* and *Joseph P. Wild*.

Marquette Appointments Announced

J. F. KUZMA, M. D.

Dr. Joseph F. Kuzma, Wauwatosa, has been appointed director of the department of pathology at Marquette University School of Medicine to succeed *Dr. W. A. D. Anderson*, who is taking a position as director of the department of pathology and laboratories at Jackson Memorial Hospital in Miami, Fla. A member of the medical school faculty for the past 13 years, Doctor Kuzma will hold the rank of professor. He has resigned as director of laboratories at Milwaukee County Hospital to accept this full-time appointment.

Another faculty member has been named associate professor. *Dr. Joseph W. Rastetter*, Wauwatosa, will serve as assistant chairman of the department of medicine.

Other appointments include *Dr. Edward A. Bachhuber*, assistant director of the department of surgery; *Dr. Wilson Weisel*, assistant clinical professor of surgery; *Dr. John L. Armbruster*, asso-

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

SENILE

For further information—
Director, Summit Hospital
Oconomowoc, Wisconsin

ciate clinical professor of radiology; *Dr. William W. Engstrom, Wauwatosa*, associate professor in the department of medicine; and *Drs. John W. Thoma, M. Alex Krembs*, and *Lionel T. Servis*, assistant clinical professors of obstetrics and gynecology. Except where otherwise noted, the physicians are from Milwaukee.

Doctor Lipscomb on Active Duty

At the completion of two years as a resident in radiology at Veterans Administration Hospital, Wood, *Dr. Thomas C. Lipscomb* has reported for active duty with the Army at Brooke Army Hospital, Fort Sam Houston, San Antonio, Texas. Before his work at Wood, Doctor Lipscomb practiced for three years in Horicon.

SOCIETY RECORDS

New Members

H. J. van Baaren, Service Memorial Institute, Department of Pathology, University of Wisconsin, Madison.

Changes in Address

A. W. Hoessel, Mosinee, to 115 McIndoe, Wausau.

W. A. D. Anderson, Milwaukee, to University of Miami School of Medicine, Coral Gables 46, Florida.

R. S. Simenson, Manitowoc, to 500 East Parkway Boulevard, Appleton.

L. L. Olson, Monroe, to 504 Wells Street, Darlington.

L. A. Van Ells, Plymouth, to Brillion Clinic, Brillion.

W. J. Little, Racine, to Valley Forge Army Hospital, Phoenixville, Pennsylvania.

R. G. Konicek, Prairie du Chien, to 1504 Kilbourn Street, Tomah.

L. N. Reis, Madison, to De Forest.

J. M. Sinnett,* Pensacola, Florida, to 5336 Yerkes Street, Jacksonville, Florida.

R. E. Oertley, Monroe, to Darlington.

O. W. Pfeiffer, Racine, to Woodruff.

L. B. Perssion, Winnebago, to Apartment 202, 1653 North Prospect, Milwaukee.

E. R. Daniels, Wauwatosa, to 2212 West State Street, Milwaukee.

Milton J. Fox, Milwaukee, to 1069 East View Drive, Rantoul, Illinois.

J. L. Guckien, Milwaukee, to Route 2, Camden, Indiana.

J. T. Hotter, West Allis, to 624 North Linn Street, Iowa City, Iowa.

D. D. Hassett, Milwaukee, to Little Company of Mary Hospital, 95th and California Avenue, Evergreen Park 42, Illinois.

W. K. McCreary,* Clovis, New Mexico, to Temple City Medical Group, 9700 East Las Tunas Boulevard, Temple City, California.

George Thorngate III, Alfred, New York, to 521 Calle Principal, Monterey, California.

J. E. Koepsell,* Fort Custer, Michigan, to 02096734, 5012 Army Service Unit, U.S.A. Inf., Ft. Sheridan, Illinois.

K. J. Stollenwerk,* Milwaukee, to 0992217, Wherry Housing Apartment No. 53B, Ft. Campbell, Kentucky.

W. H. Williamson, San Francisco, California, to 1101 Grand Avenue, Racine.

R. G. Welsch, Creston, Iowa, to 723 58th Street, Kenosha.

S. B. Crepea, New York, to Allergy Clinic, Wisconsin General Hospital, Madison.

J. F. Kuzma, Wauwatosa, to Department of Pathology, Marquette University School of Medicine, 561 North 15th Street, Milwaukee.

J. D. Silbar, Camp Atterbury, Indiana, to Apartment 5, 131 Langdon Street, Madison.

W. F. Lorenz, Madison, to Pine Point, Gordon.

P. J. Bartzen, Milwaukee, to New Topsail Beach, Holly Ridge, North Carolina.

J. G. Frisch,* Seneca Falls, New York, to 2225 East Newton, Milwaukee.

R. C. Brown, Milwaukee, to Midelfart Clinic, Eau Claire.

*Military Service.

DEATHS

Dr. Frank A. Wier, Racine eye, ear, nose, and throat specialist, died on May 26 at the age of 70. He was born in Tomah on February 5, 1883.

A 1904 graduate of Ensworth Medical College in St. Joseph, Missouri, Doctor Wier took additional work in his specialty at the School of Medicine of the University of Chicago, St. Louis University, the Chicago Eye, Ear, Nose, and Throat College, and the Mayo Clinic.

In addition to his private practice in Racine, Doctor Wier was on the staff of St. Mary's and St. Luke's Hospitals. He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his wife, Maude.

Dr. Edward J. Campbell, Cecil physician, died suddenly on June 2 after making morning rounds at the Shawano Municipal Hospital. He was 64.

Son of the late Dr. Bernard Campbell of Monches, Doctor Campbell was born on August 12, 1888. After his graduation from Marquette University School of Medicine in 1911 and a year's internship at Grinty Hospital in Milwaukee, he worked for several years for the Duluth, Mesabi and Northern Railroad and later became associated with the Chicago, Burlington, and Quincy (Burlington Route) Railroad at Lincoln, Nebraska.

Nineteen years ago he came to Cecil to set up private practice. He had formerly served as city health officer in Oshkosh.

Doctor Campbell was a member of the Shawano County Medical Society, the State Medical Society

Prescribe Journal-advertised products and you prescribe the best.

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

of Wisconsin, and the American Medical Association.

Survivors include the doctor's wife, Sarah; five daughters; and three sons.

Dr. David E. W. Wenstrand, former medical director of the Northwestern Mutual Life Insurance Company in Milwaukee, died on June 4 in Tryon, North Carolina, where he had been living since his retirement in 1950. He was 77.

Born in Sweden on May 6, 1876, Doctor Wenstrand came to this country with his parents when he was 4. In 1900 he received his medical degree from Northwestern University Medical School and served his internship at Cook County Hospital in Chicago.

In 1903 he came to Milwaukee as assistant medical director of Northwestern Mutual, a post he held until 1936, when he was appointed medical director.

A member of county, state, and national medical societies, Doctor Wenstrand also served as secretary, council member, vice-president, and president of the Milwaukee Academy of Medicine, president of the Association of Life Insurance Medical Directors of America, and national president of Phi Rho Sigma medical fraternity. He held membership in the Chicago Pathological Society.

Survivors include his wife, Margaret; a son, Eric, Chicago; and two daughters, Mrs. Janet Hatfield, Seattle, Washington, and Sally, Tryon.

Dr. Henry F. Deicher, Plymouth physician for 50 years, died on June 5 after a lingering illness. Born in Rhine on June 4, 1873, he reached his 80th birthday the day before his death.

A 1903 graduate of the College of Physicians and Surgeons in Milwaukee (now part of Marquette University), Doctor Deicher had a record of 50 years of continuous service to Plymouth—and his medical practice was only part of his active contribution to community life. He was health officer of Plymouth for 34 years, president of the Plymouth Foundry and Machine Company for 25 years, president of the Plymouth Building Association for 24 years, and a member of the advisory committee of the Citizens State Bank.

In April of this year the Plymouth Kiwanis Club launched a scholarship drive in Doctor Deicher's honor. Funds obtained in the drive will be used to help graduates of Plymouth High School who wish to enter medical school.

The week of Doctor Deicher's death, June 1 to 6, was declared Dr. Henry F. Deicher Week in a resolution by the Plymouth Common Council to mark his half-century of service.

The doctor was a member of the Sheboygan County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by a brother, Herman Deicher of Oshkosh. Doctor Deicher's wife died in 1942.

Dr. Corwin E. Bugher, retired Ladysmith physician, died on June 5 in Wilmington, Delaware.

Born on May 28, 1861, he was 92 years old at the time of his death.

A native of Ohio, Doctor Bugher was a graduate of the Medical College of Ohio (now part of the University of Cincinnati). On receiving his degree in 1887, he set up practice in Caldwell, Ohio, and in 1891 moved to another Ohio town, Paulding. In 1910 he settled in Ladysmith. Since his retirement in 1949, the doctor and his wife had been living in Wilmington at the home of their son George.

His wife, Alta, and two sons, George, and Charles A. of Eau Claire survive him.

Dr. Alexander Montgomery, Milwaukee surgeon, died suddenly on June 8. On June 18 he would have been 64 years old.

A native of Eau Claire, Doctor Montgomery was a graduate of the University of Illinois and Marquette University School of Medicine. On receiving his M. D. degree in 1909, he took postgraduate work at Johns Hopkins University, Yale, and the University of Illinois.

Doctor Montgomery maintained an office for the private practice of surgery in Milwaukee and was affiliated with Deaconess Hospital, where he formerly served as chief of surgery. At various times he had been associated with Johnston Emergency Hospital, St. Anthony's Hospital, and the old Milwaukee General Hospital.

A member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association, Doctor Montgomery was also a fellow and life member of the American College of Surgeons and of the International College of Surgeons.

Survivors include his wife; a daughter, Mrs. William H. Ness, San Mateo, California; and a brother, Dr. Robert P. Montgomery, Milwaukee.

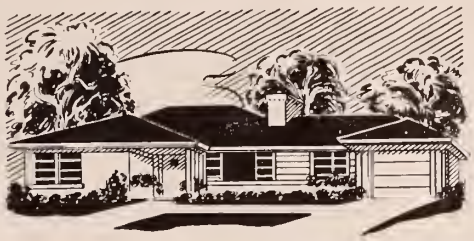
Dr. John Martin Scantleton, Sparta physician and surgeon since 1915, died on June 16 at the age of 63. He was born in Cataract on September 19, 1889.

Doctor Scantleton attended the University of Wisconsin and received his medical education at Northwestern University Medical School, graduating in 1913. After a 22-month internship at Denver (Colo.) County Hospital, he set up practice in Sparta, first in partnership with the late Dr. Hugh H. Williams and then with the late Dr. Charles S. Phalen, a friend from his days at Northwestern. He was made a member of the staff of St. Mary's Hospital in 1915 and held this post until his death.

During World War I Doctor Scantleton left his Sparta practice for over a year to serve as a captain with the 32nd Division in France. Before his release from the armed forces in 1919, he was awarded the Croix de Guerre.

Doctor Scantleton was a member of the Monroe County Medical Society, of which he served as president in 1933 and 1938, the State Medical Society of Wisconsin, and the American Medical Association.

His wife, the former Doris Richards of Sparta, survives him.



MORTGAGE PAID and INTEREST SAVED

Suppose that A has a $10,000 mortgage on his home. It is amortized over a 20-year period. At 5% his monthly payment on principal plus interest is $66.00. He owns one of our low-cost mortgage cancellation policies.

At his death our policy will pay-off the mortgage in full and all future interest is saved and that is a big item. Twenty years involves 240 payments. 240 times $66.00 is $15,840. So if his death occurs now, $5,840.00 in interest is saved for the widow. Moreover, she immediately has an asset that she owns and controls. Fill out and mail the coupon below for details to the Wisconsin Life Insurance Company, 30 West Mifflin Street, Madison, Wisconsin.

Please send me full details without obligation about your low-cost mortgage policy.

Name _____

Address _____

My Date of birth is _____

Distributors to the profession

of fine

Injectable Vitamins and Endocrines

Interstate Pharmacal Company

P. O. Box 252 Beloit, Wis.

MAIL ORDERS SHIPPED IMMEDIATELY

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clyboum St. Milwaukee 3, Wisconsin

Dr. Frank W. Pfisterer, Milwaukee physician and surgeon, died on June 16 at the age of 66. He was born in New Ulm, Minnesota, on July 20, 1887.

A 1913 graduate of Marquette University School of Medicine, Doctor Pfisterer practiced medicine for 22 years in Markesan. Since 1937 he practiced in Milwaukee, though in recent years failing health forced him to carry a lighter load.

Survivors include his wife, Elsie, and a son, Dr. William Pfisterer of Chicago.

Dr. Victor S. Falk, physician at Mendota State Hospital in Madison, died on June 28. He was 64 years old.

A native of Stoughton, Doctor Falk was born on March 4, 1889. On his graduation from Rush Medical College, Chicago, in 1913, he served a year's internship at Chicago's St. Joseph's Hospital and then returned to Stoughton to set up an office for the practice of internal medicine. He served during World War I as a contract surgeon. In 1931 he moved to Milwaukee, where he worked as a heart specialist for 14 years. Between 1944 and 1947 he was a captain in the Army Medical Corps, stationed first at the Veterans Administration Hospital in Wood and later in Green Bay. Before his appointment to the staff of Mendota State Hospital in 1949, he had a private practice in Green Bay for two years.

He is survived by his wife, Gretchen; a daughter, Mrs. George C. Weber, Jr., Wauwatosa; and a son, Victor S., Jr., an Edgerton physician.

Dr. Guy C. Waufle, Janesville physician and surgeon for 48 years, died on June 18. He was born in Rock Prairie.

Doctor Waufle was a 1903 graduate of the University of Illinois College of Medicine. That same year he began his practice at Capron, Illinois. He moved to Janesville in 1905 where for several years he served as health officer. He was a member of the staff of Mercy Hospital.

Well known as a sportsman, Doctor Waufle was an ardent baseball fan and gave many hours of free professional service to baseball players with the Janesville Cubs and visiting teams. A devotee of harness racing, his stable produced a number of top standard breeds, including Mark Hanna.

Doctor Waufle held membership in the Rock County Medical Society, of which he was a past president, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include the doctor's wife, Maude, and two sons, Donald of Milwaukee and Victor, Rockford, Illinois.

Dr. Stanley Leon Krzysko, Milwaukee physician and surgeon, died on June 26 after a brief illness. Born in Milwaukee on November 16, 1882, he was 70 years old at the time of his death.

A 1911 graduate of Northwestern University Medical School, Doctor Krzysko received his license to practice in Wisconsin in July of that year. After a year's internship at Milwaukee County Hospital and

a six-month internship at Chicago Lying-In Hospital, he practiced briefly in Latimer, Iowa, and then completed his educational work with a postgraduate course at the School of Surgical Technic in Chicago.

After setting up practice in Milwaukee, Doctor Krzysko joined the surgical staff of St. Luke's Hospital. In 1939 he served as chief of staff at the hospital.

A member of county, state, and national medical societies, Doctor Krzysko was secretary of the Medical Society of Milwaukee County in 1939 and held membership in the Polish Medical and Dental Association, of which he was a past president.

He is survived by his five daughters.

Dr. Charles F. Peterson, oldest practicing physician in Trempealeau County, died at his home in Independence on June 30. He was 82 years old.

Doctor Peterson was born in Prussia on June 5, 1871. In 1884 he came to the United States with his parents and settled in Arcadia. On his graduation from Arcadia High School he taught for several years in rural schools in Wisconsin and received a degree from River Falls Normal College in 1900. Turning to medicine, he entered Northwestern University Medical School, graduating in 1907. His medical practice in Independence began the same year.

During his 46 years of practice it is estimated that Doctor Peterson delivered about 2,700 babies. Last July the Independence Lions Club held a "Dr. Peterson Day" to mark his long years of service.

For more than 36 years Doctor Peterson served as a member of the school board and will be remembered for his part in obtaining a new high school for Independence. In 1937 impaired hearing forced him to retire from this civic post.

A member of county, state, and national medical societies, Doctor Peterson was granted life membership in the State Medical Society in 1949.

Surviving are his wife, Helen, and a son, Dr. Donald Peterson, a member of the staff of the Krohn Clinic at Black River Falls.

H. A. JEGI, M. D.

Dr. Henry A. Jegi, Galesville physician for 56 years, died on June 27 at the age of 80. He was born in Arcadia on April 16, 1873.

An 1896 graduate of the Chicago College of Physicians and Surgeons (now part of the University of Illinois), Doctor Jegi set up practice in Galesville on May 1, 1897. Active in organized medicine, Doctor Jegi was one of the founders in 1904 of the Trempealeau County

COMPLETE OPHTHALMIC SERVICE FOR THE PROFESSION

SINCE 1913

Complete Laboratories Serving Wisconsin:
Beloit, Wis. Duluth, Minn. Eau Claire, Wis. La Crosse, Wis. Stevens Point, Wis. Superior, Wis. Wausau, Wis.

Benson OPTICAL COMPANY

EXECUTIVE OFFICES • MINNEAPOLIS, MINN.

Prescribe Journal-advertised products and you prescribe the best.

Medical Society and at various times held all the offices of the organization. For three terms he served as Councilor of the Seventh District of the State Medical Society and in 1925 was its vice-president. He received the pin of the Fifty Year Club of the Society in 1948. In 1952 he was granted life membership, an honor which only a small group of Wisconsin physicians can claim.

Galesville considers one of Doctor Jegi's greatest contributions to be his organization of the first Christmas seal sale in the village in 1903. In his work as a leader in the fight against tuberculosis, Doctor Jegi served for 20 years as a member of the board of directors of the Wisconsin Anti-Tuberculosis Association. At the time of his death he was a member of the state senior council of the organization. In 1948 *The Crusader*, official publication of the WATA, dedicated an issue to Doctor Jegi as the "typical family doctor."

Prominent in community affairs, Doctor Jegi served for 36 years as president of the board of education and for one term as president of the village board. He was a member of the board of directors of the Bank of Galesville and director of the Gale Packing Company.

Doctor Jegi's first wife died in 1933 after 35 years of marriage. He is survived by his second wife, Ruby, and the children of his first marriage, Henry of La Crosse and Mrs. Milton Olson of Balsam Lake.

NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY

525 Holly Avenue, Madison 5, Wisconsin

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses - 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting September 14, September 28, October 12
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26
Surgical Anatomy & Clinical Surgery, Two Weeks, starting August 17, November 9
Gallbladder Surgery, Ten Hours, starting October 26
General Surgery, One Week, starting October 5
Surgery of Colon & Rectum, One Week, starting September 21
Basic Principles in General Surgery, Two Weeks, starting September 21
Thoracic Surgery, One Week, starting October 12
Esophageal Surgery, One Week, starting October 19
Breast & Thyroid Surgery, One Week, starting October 26
Fractures & Traumatic Surgery, Two Weeks, starting October 26
GYNECOLOGY—Intensive Course, Two Weeks, starting September 21
Vaginal Approach to Pelvic Surgery, One Week, starting August 31
OBSTETRICS—Intensive Course, Two Weeks, starting October 5
DERMATOLOGY—Intensive Course, Two Weeks, starting October 19
MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting October 12
Intensive General Course, Two Weeks, starting September 28
Gastroenterology, Two Weeks, starting October 26
Allergy, One Month and Six Months, by appointment
CYSTOSCOPY—Ten-Day Practical Course starting every two weeks
UROLOGY—Intensive Course, Two Weeks, starting September 28

Teaching Faculty—Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

17-Ketosteroid Determinations

Quantitative Gonadotrophin Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

Coming Events

International College of Surgeons

Annual Congress to be held at the Waldorf–Astoria Hotel, New York, from September 13 through 17, 1953. For further information write to 1516 Lake Shore Drive, Chicago 10, Illinois.

Mississippi Valley Medical Society

Eighteenth Annual Meeting to be held at the Elk's Club, Springfield, Illinois, from September 23 through 25, 1953. For further information write to W. C. U. Building, Quincy, Illinois.

American College of Surgeons

Annual Clinical Congress to be held at the Conrad Hilton Hotel, Chicago, from October 5 through 9, 1953. For further information write to 40 East Erie Street, Chicago 11, Illinois.

American Association of Blood Banks

Sixth Annual Meeting to be held at the La Salle Hotel, Chicago, from October 17 through 20, 1953. For further information write to 3500 Gaston Avenue, Dallas 4, Texas.

Mississippi Valley Trudeau Society and Mississippi Valley Conference

This meeting will be held at the Nicollet Hotel, Minneapolis, Minnesota, from October 15 through 17, 1953. For further information write to the Minnesota Tuberculosis and Health Association, 614 Portland Avenue, Saint Paul 2, Minnesota.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 **Milwaukee, Wis.**

Medication Alone Does Not Solve **THE ALCOHOLIC PROBLEM**

AT IVANHOE—

a specially trained staff deals with the psychiatric, psychological and social aspects of the psychosomatic illnesses resulting in Alcohol Addiction.

Latest therapies and "know-how" have reduced the treatment period to an average of five days. Moderate fees.

Phone or write for information or reservation.

Alcohol patients only.

Restful Homelike Atmosphere
Near the Shores of Lake Michigan

IVANHOE SANITARIUM

of MILWAUKEE, WIS.

A REGISTERED HOSPITAL OF A.M.A.
Member American & Wisconsin Hosp. Assns.

2203 E. IVANHOE PLACE
Phone MArquette 8–4030

Accepted by the Medical Societies
Dedicated to the Medical Profession

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

PHYSICIAN WANTED as associate in busy, successful practice including surgery in rural, resort, and railroad town of 3,000 in northwest Wisconsin Indianhead region. Fully equipped 13-room modern brick clinic to be completed Sept. 1. Excellent hospital facilities near-by. Local hospital building campaign under way. Salary, percentage, or guaranteed minimum basis initially, with eventual partnership. Address replies to Box 496 in care of the Journal.

CLINIC in Milwaukee needs general practitioner, internist, and pediatrician. Address replies to Box 488 in care of the Journal.

WANTED: G.P. to work with 2 other G.P.'s in a modern and complete office in south-central Wisconsin. Modern hospital within 15 miles. Ideal hours and working conditions. Address replies to Box 499 in care of the Journal.

EXCELLENT opportunity for general practitioner in a small group located in northeastern Wisconsin. Percentage basis with liberal salary guarantee until established. Permanent position. Address replies to Box 500 in care of the Journal.

FOR SALE: 30 ma Continental x-ray and vertical fluoroscope, used, shock proof. Accessories include tank, hand timer, and cassette holder. Address replies to Box 517 in care of the Journal.

FOR SALE: Office equipment and instruments of a recently deceased Wisconsin physician. Address replies to Box 518 in care of the Journal.

FOR SALE, by widow of physician, examination table, office desk, and an assortment of instruments. Address replies to Box 519 in care of the Journal.

ASSOCIATE WANTED who has had some surgical training and experience. Office and hospital of 20 beds in same building. Practice is located in county seat of 6,000 in southwestern Wisconsin—excellent railroad facilities. Salary open, partnership opportunity. Address replies to Box 520 in care of the Journal.

FOR SALE: Schindler-Cameron flexible gastroscope, completely equipped and in perfect condition. Also a Boros-Cameron flexible esophagoscope (never used) with hooked handle. Completely equipped. Address replies to Box 503 in care of the Journal.

OPHTHALMOLOGY LOCATION WANTED: UW graduate, returning to Wisconsin for family and business reasons, wishes association with board member ophthalmologist. Training includes 3-year residency in EENT and basic science course in eye followed by several years of EENT practice. Could give excellent office and surgical assistance. Arrangements of association open. Address replies to Box 508 in care of the Journal.

EENT OFFICE FOR SALE OR RENT in community of 5,000 in east central Wisconsin. Owner retiring after 50 years of practice. Excellent 50-bed hospital. No charge for good will or introduction. Wonderful chance for right man. Address replies to Box 509 in care of the Journal.

GENERAL PRACTITIONER BADLY NEEDED in Adams-Friendship. Large practice with little competition. Local incorporated association ready to provide backing. Railroad guarantees at least $2,000 a year. Office and home available and rent free for 3 months. Hospital with ambulance facilities near by. Contact Harold T. Johnson, Adams, Wis.

FOR SALE: Medium size autoclave, two water sterilizers and instrument sterilizer (gas fired), excellent condition. Ideal for clinic or small hospital. Write I. Jansen, 723 Fifth Avenue, Antigo, Wis.

FOR SALE: Rhythmic constrictor with one cup. Very good condition. For information contact Mr. Robert Serns, 908 Linden Ave., Jefferson, Wis.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately. Write Box 505 in care of the Journal.

FOR SALE: Spencer microscope in carrier. Also other physician's instruments. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

MD WANTED for small group operating clinic and 25-bed modern hospital in rural town close to large city in southwest Wisconsin. $12,000 minimum first year, then partnership. Qualifications should include enough surgical experience to cope with accidents and major surgical emergencies. Excellent modern house available. Send details in first letter to Box 506 in care of the Journal.

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WANTED: General practitioner to join two-man group in thriving midwestern Wisconsin college community. Salary guaranteed first year, then partnership; new modern hospital facilities available. Address replies to Box 510 in care of the Journal.

PHYSICIAN-SURGEON WANTED for industrial community serving 3,000 people within a 20 mile area. We will lease attractive doctor's residence and a fully equipped small first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year of practice and should increase each year thereafter. Available for immediate occupancy. Call or write the Goodman Lumber Company, Goodman, Wis.

FOR SALE: Office equipment of general practitioner including mobile GE, D-2 model, x-ray unit and accessories; microscope; instruments; sterilizer; scales; instrument and drug cabinets; and office furniture. Address replies to Box 511 in care of the Journal.

FOR SALE OR EXCHANGE: Central Wisconsin practice of retiring physician and surgeon in very desirable, prosperous rural community. Finest modern hospital facilities available. Doctors have practiced from this location for over 45 years. Property includes brick home, office facilities, waiting room, dispensary, and two-car brick garage. The lot is approximately 80 by 180, wooded and landscaped. Office equipment, instruments, etc., if desired. Financing available. Address replies to Box 512 in care of the Journal.

FOR SALE OR LEASE: Lucrative general and clinical practice in south-central Wisconsin. Farm, industrial, resort area. Suitable for one or two men, veteran category IV preferred. Many transferable appointments, one of which will pay all purchase costs. Good hospital, living, religious, and recreational facilities. Physician needed by October 1. Owner specializing, but will introduce new man thoroughly. Address replies to Box 513 in care of the Journal.

PHYSICIAN-SURGEON WANTED: To associate with a long established 3-man fully equipped clinic. City of 4,000 with class A hospital connections. Surgical experience preferred. Percentage, salary, and partnership. Address replies to Box 514 in care of the Journal.

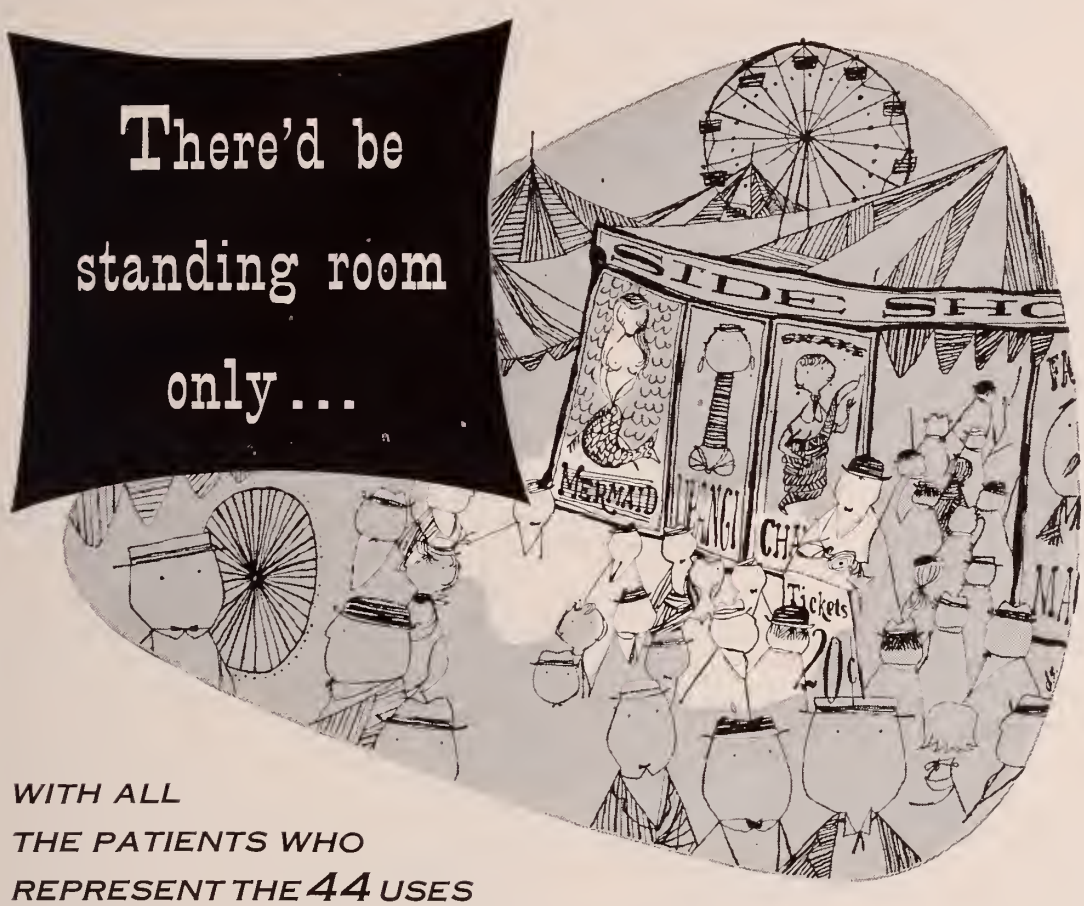
RADIOLOGIST who completed residency July 1 available for association, hospital, or group. Will consider part-time work within commuting distance of Milwaukee. Address replies to J. E. Abrams, M. D., 2641 N. 48th St., Milwaukee 10, Wis.

UNUSUAL OPPORTUNITY FOR A GENERAL PRACTITIONER to take over a large practice established for more than 25 years in St. Paul, Minn. Owner must retire because of poor health. Latest equipment optional including a completely furnished lab, shock-proof x-ray, EKG, diathermy, basal metabolism, cautery, etc. Will introduce. Address replies to Box 515 in care of the Journal.

OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

ASSOCIATE WANTED in a general practice located in south-central Wisconsin. Veteran, priority IV, preferred. Good hospital, living, religious, and recreational facilities. Excellent return on percentage basis. Needed immediately. Address replies to Box 516 in care of the Journal.

There'd be standing room only...



WITH ALL THE PATIENTS WHO REPRESENT THE 44 USES FOR SHORT-ACTING

Nembutal®

FROM report to report on short-acting NEMBUTAL, these are the facts that you'll find the same:

1 *Short-acting* NEMBUTAL (*Pentobarbital, Abbott*) *can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.*

2 *The dosage required is small—only about half that of many other barbiturates.*

3 *There's less drug to be inactivated, shorter duration of effect, wide margin of safety and little tendency toward morning-after hangover.*

4 *In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.*

All are sound enough reasons for your prescription to call for short-acting NEMBUTAL. How many of short-acting NEMBUTAL's 44 uses have *you* tried?

Abbott

FOR BRIEF AND PROFOUND HYPNOSIS

try the 0.1-Gm. (1½-gr.) NEMBUTAL *Sodium capsule.*

1-186A

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmelster, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

Page
Abbott Laboratories ---------- 14, 15, 45
Audiphone Utilities ---------- 38
Ayerst, McKenna & Harrison, Ltd. ---------- 10

Barr X-Ray Company ---------- 39
Benson Optical Company ---------- 41
Bergmann Prescription Center ---------- 29

Central Drug ---------- 29
Ciba Pharmaceutical Products ---------- 16
Coca-Cola Company ---------- 40
Cook County Graduate School of Medicine ---------- 42

Doerflinger Artificial Limb Co. ---------- 38
Doris Appel Medical Sculptures ---------- 12

Endocrine Laboratories ---------- 42

Hotel Schroeder ---------- 5
House of Bidwell ---------- 25
Hurley X-Ray Company ---------- 38

Interstate Pharmacal Company ---------- 39
Ivanhoe Sanitarium ---------- 43

Karrer Company ---------- 21
Keeley Institute ---------- 32
Kennedy–Mansfield ---------- 29

Lederle Laboratories ---------- facing page 18
Lilly, Eli and Company ---------- 8, 9, 22
Linde Air Products ---------- 33

Mallard, Incorporated ---------- 19
Mallatt Pharmacy ---------- 29
Mather Pharmacy ---------- 29
Mayer Drug ---------- 29
Mead Johnson and Company ---------- 49
Medical Book Guild of America ---------- 6
Medical Protective Company ---------- 5
Merck and Company ---------- 20
Milwaukee Sanitarium ---------- 50

New York Polyclinic ---------- 4

Orthopedic Appliance Company ---------- 43

Parke, Davis and Company ---------- 2, 3
Pfizer, Charles and Company, Inc. ---------- 17
Physicians Casualty Association ---------- 31
Pogue, Mary, School ---------- 28
Professional Business Service ---------- 463

Rennebohm's ---------- 29
Roemer Drug Company ---------- 34
Rogers Memorial Sanitarium ---------- 50

S. and L. Signal Company ---------- 42
Sacred Heart Sanitarium ---------- 35
St. Croixdale Sanitarium ---------- 5
Schering ---------- 11
Schieffelin and Company ---------- 34
Searle, G. D. and Company ---------- 23
Shorewood Hospital Sanitarium ---------- 31
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp. ---------- 7
Stanley, Inc. ---------- 4
Summit Hospital ---------- 36

Time Insurance Company ---------- 461

Upjohn Company ---------- 13

Winthrop–Stearns, Inc. ---------- 18
Wisconsin Life Insurance Company ---------- 39

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. F. Boock 119½ Front Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	N. E. Bear Monroe	D. E. Mings Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Second Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 SEPTEMBER 1953 Number 9

Fetal Salvage in a Fatal Case of Maternal Cerebral Hemorrhage Complicating Pregnancy

By DONALD D. HASSETT, M. D.

Evergreen Park, Ill.

SUBARACHNOID hemorrhage is a rare complication of pregnancy, but it does occur and must be considered in the diagnosis of the comatose gravid female. Prompt diagnosis and definitive treatment are essential to the mother's survival and, when her prognosis is grave, fetal salvage also becomes a major problem.

Such accidents may happen at any time during the reproductive years.[1] As Decker and Rowe recently have emphasized, the clinical course depends on the etiology, the size of the involved vessel, and the extent of hemorrhage.[2] The onset is acute in most cases. Bleeding may be limited, producing minimal signs and symptoms,[3] or it may be massive, quickly leading to coma and death.[4] It is in the latter situation that a decision must be made for safety of the child in utero.

Where the initial episode is not fatal and improvement takes place, the decision must be made whether to attempt surgical treatment of the arterial lesion before labor. Since the effort of delivery may cause further bleeding from an aneurysm,[5,6] the fate of the mother hinges on this decision.

In the comatose patient, however, the question of delivery of a living infant and its effect on the mother's prognosis must be weighed. Postmortem cesarean section may yield a dead child or one hopelessly crippled from prolonged anoxia. Early abdominal delivery, on the other hand, may jeopardize the mother's life. The following case report describes our experience with this problem.

Case Report

M.M., a 37-year-old gravida IV, Para III white housewife, (Case 17426), 34 weeks pregnant, was admitted to the hospital in coma at 7:30 a.m. on Aug. 11, 1952. Her last menstrual period had begun on Dec. 14, 1951, and the estimated date of confinement was Sept. 20, 1952.

The patient's general health had been good and this pregnancy uneventful, as her others had been. She had retired at 11 o'clock the previous night, with no complaints at that time. She had awakened at 4:30 a.m. on the admission day with a severe right frontal headache. This persisted and about one hour later, while preparing breakfast, she had a convulsive episode, collapsed, and became comatose.

Because of the convulsion, resembling a grand mal seizure, presumptive admitting diagnosis was eclampsia. Blood pressure was 140/78 and pulse rate 120 per minute. Recurring spasticity and relaxation were present over the entire body, most marked on the right side. Babinski reflex was present on the right and equivocal on the left, later becoming demonstrable bilaterally. There was no edema of the face or extremities. A diagnosis of subarachnoid hemorrhage was proposed after examination. On order of the attending physician 8 mg. of morphine, 120 mg. of sodium luminal, and 40 cc. of 50 per cent glucose were administered. Oxygen was started by nasal catheter.

At approximately 9:30 a.m., the patient became cyanotic and spontaneous respiration ceased. A rubber airway was inserted and oxygen was administered under positive pressure with an anesthesia machine. Independent respiration was never re-established. Blood pressure became unobtainable as the pulse rate increased to 160; fetal heart tones, of poor quality, remained audible at 160 to 200.

The patient was given 1.2 mg. of intravenous digitoxin and 500 mg. of intravenous caffeine sodium benzoate. When the blood

From the service of Dr. Fabian Derse and the Department of Obstetrics, St. Mary's Hospital, Milwaukee, Wisconsin.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

pressure rose to 60/40, a retention catheter was inserted and 400 cc. of clear urine, negative for albumin, sugar, and cells, was obtained. A diagnostic lumbar puncture was performed and spinal fluid, grossly clear, flowed readily under normal pressure.

Examination of the fluid revealed erythrocytes 288 per cubic millimeter, leukocytes 0, sugar 108 mg. per cent, protein 200 mg. per cent, and globulin positive.

Intravenous infusion of 500 cc. of 20 per cent glucose with 5 cc. of aqueous adrenal cortex was started at 11:20 a.m. Twenty minutes later, the patient's blood pressure was 78/54 and the fetal heart tones were of good quality. By 1:20 p.m., the blood pressure was 150/80.

The obstetric consultant (Dr. Louis J. Paquette) who saw the patient at this time advised immediate labor induction, if possible. He felt that the mother's critical respiratory status was a hazard to the fetus; that delivery should be accomplished promptly; and that vaginal delivery in a multipara would be less likely to cause shock than a cesarean section would. Consequently, 5 U.S.P. units of Pitocin was added to the infusion. A dose of 600,000 units of repository penicillin was given intramuscularly.

Under constant artificial respiration, color remained good and the chest clear. By 3:00 p.m., blood pressure had stabilized at 120/80; pulse was full and regular at 120; and fetal heart tones were strong and regular at 160.

Intermittent uterine contractions were established and the dextrose-Pitocin infusion was repeated. Contractions were unproductive, however, and at 6:00 p.m. no significant cervical effacement or dilatation was noted.

After a neurologic consultation, a lumbar tap was repeated by the neurologist (Dr. Francis J. Millen) with similar findings. All reflexes were absent, there was no response to pain stimuli, and pupils were dilated to 7 mm. bilaterally and were fixed. Funduscopic examination revealed suggestive choking of the left disk, no vessel pulsation, and visible myelinated fibers of the right disk. The neurologist's impression was right subarachnoid hemorrhage, probably due to ruptured aneurysm, with a fatal prognosis.

On the basis of this opinion, classical cesarean section without anesthesia was performed in the patient's bed with delivery at 9:15 p.m. of a living 5-pound 2-ounce female, apparently normal. Resuscitation and cry were spontaneous and immediate.

Maternal blood loss was minimal; the mother's condition remained unchanged throughout surgery. She received additional intravenous dextrose during the procedure, followed by 500 cc. of whole blood. At 10:55 p.m., her blood pressure was 90/74, her pulse full and regular at 108. A cuirasse-type plexiglass respirator, obtained from the Milwaukee County General Hospital, was applied to the patient's chest as oxygen was continued by mask.

There was no significant change in the patient's condition throughout the night. Blood pressure, checked at 15-minute intervals, was stable, and pulse was regular at 96 to 100 until 5:45 a.m. Medication was limited to intramuscular Ergotrate at 4-hour intervals, penicillin, and sodium sulfacetimide ophthalmic ointment. Urinary output continued normal.

Rising pulse rate was noted at 6:00 a.m. when moist rales became audible and secretions of mucus began to accumulate in the hypopharynx despite suctioning. Though she improved briefly after the intravenous administration of Coramine, cyanosis was progressive and pulse rate increased to 140. Blood pressure and pulse then became unobtainable; with all vital signs absent, she was pronounced dead at 7:00 a.m. on August 12.

Immediate necropsy by Dr. S. B. Pessin disclosed massive hemorrhage of the right cerebral hemisphere, temporoparietal region, owing to the rupture of a congenital aneurysm. Clotted blood covered the right hemisphere, while a firm clot about the size of a small lemon occupied a depression on the surface of the temporal lobe. Subsequent examination of brain sections localized the lesion to a branch of the right middle cerebral artery.

Other significant necropsy findings were encephalomalacia, pulmonary congestion, emphysema and focal atelectasis, and chronic epicarditis.

The infant had an uncomplicated neonatal course. She gained weight readily, showed apparently normal physical and mental development on repeated examination, and was discharged from the nursery on September 28, weighing 7 pounds 12 ounces.

Summary

A case of fatal cerebral hemorrhage in a 34-weeks pregnant multipara is presented. Cesarean section performed 12 hours after respiratory failure yielded a living, normal female infant when labor induction proved unsuccessful.

Little Company of Mary Hospital.

REFERENCES

1. McDonald, C. A., and Korb, M.: Intracranial aneurysms, Arch. Neurol. & Psychiat. 42:298–328 (Aug.) 1939.
2. Decker, A., and Rowe, E. C.: Subarachnoid hemorrhage complicating pregnancy, Am. J. Surg. 85: 561–563 (April) 1953.
3. Wechsler, I. S.: A Textbook of Clinical Neurology, ed. 5, Philadelphia, W. B. Saunders Co., 1943.
4. DeJong, R. N.: The Neurologic Examination: Incorporating the Fundamentals of Neuroanatomy and Neurophysiology, New York, Paul B. Hoeber, Inc., 1950.
5. Parker, H. L.: Aneurysms of cerebral vessels; clinical manifestations and pathology, Arch. Neurol. & Psychiat. 16:728–746 (Dec.) 1926.
6. Taylor, A. B., and Whitfield, A. G. W.: Subarachnoid hemorrhage based on observations of 81 cases, Quart. J. Med. 5:461–472. (Oct.) 1936.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 37 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WCAN	Milwaukee	Sunday	6:15 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:45 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	4:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:15 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:00 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Recognizing Emotional Problems in Adolescent Girls

By CARL L. KLINE, M. D.
Milwaukee

ADOLESCENT girls are engaged in the difficult struggle to establish themselves as emotionally mature adult women. Adolescence is the transitional period between childhood and adulthood. The adolescent girl is attempting to (1) work out the problems associated with the breaking of dependency ties with her parents and (2) accept the sexual aspects of her role as a woman.

As one would expect, and as everyone knows from experience, this age span is likely to be a rather stormy period emotionally. Most girls manifest some behavior which is difficult to understand and which is, at times, difficult to cope with. It is this fact which often makes it difficult to evaluate the significance of emotional difficulties in this age group from the standpoint of diagnosis and treatment. One is often faced with the question: Is this "normal" adolescent behavior or is it indicative of psychopathology?

It is exceedingly important to evaluate these problems accurately and to make positive recommendations when problems exist. The whole future of the individual girl may well hinge upon whether she gets adequate help at this crucial time in her life. She is ill prepared to cope effectively with the complexities of adult womanhood if she is still burdened with the unresolved conflicts of childhood.

The writer had an opportunity to spend a year surveying emotional problems in 2,250 college girls during one academic year. This paper is based upon observations made during that study, together with additional material derived from private practice and from a survey of pertinent literature. While boys and girls in the adolescent years present many problems in common, there are some problems peculiar to each sex. This paper will focus upon the problems of adolescent girls.

Definition of the Problem

As used here, the term "emotional illness" designates a wide variety of patterns of reaction. Any persistent, emotionally determined disturbance in the total effective functioning of an individual constitutes an emotional illness. Included in this category are such diversified, yet related, conditions as schizophrenic reactions, the psychoneuroses, depressions, character disturbances, psychosomatic reactions, symptomatic situational disturbances, and some non-specific adjustment difficulties.

Scope of the Problem

The scope of the problem of emotional illness in female adolescents should be viewed from two vantage points: (1) the actual incidence and the immediate effects of illness during adolescence and (2) the effects and implications of such illness in a long-term perspective.

Incidence. There are no adequate figures available on the actual incidence of over-all emotional illness in girls of this age group. In the writer's one-year survey of 2,250 college women, 22.7 per cent manifested some kind of significant emotional disturbance during the year. Ten per cent of the total group experienced well-defined psychotic, neurotic, or character disturbances. These figures are probably representative of the incidence of such disturbances in young women. The immediate effects of such illness will be discussed below.

Long-term Implications. In studying older women suffering from emotional illness, it is extremely common to hear from them that they first had some kind of emotional illness during their teens or early twenties. After a brief or a prolonged struggle, depending upon the type of illness and upon the individual, the symptoms improved or disappeared. As time passed, there were occasional recurrences of symptoms and sometimes severe episodes of illness. Such women often end their story by expressing regret that they did not work out their problems when they first began.

Recognizing Emotional Illness

What are some of the overt manifestations of emotional illness in adolescent girls? What are some of the early signs and symptoms likely to be? In the diagnosis of any kind of

illness, it is important to know which signs and symptoms are important and what they mean.

In general it can be said that when a youngster shows any rather sudden change in any of her usual patterns of behavior, one should suspect the existence of some significant emotional difficulty. Also, any girl who is having persistent adjustment difficulties in any area of her daily living must be considered to have some kind of emotional illness until proved otherwise.

Adolescent girls will often first show evidence of beginning symptomatic emotional illness by difficulties in one or more of these four areas: (1) scholastic, (2) social, (3) physical, and (4) disciplinary.

Scholastic. A girl who has been doing well scholastically begins to do poor work or to fail. She sometimes develops an attitude of indifference to her school work. But just as often she becomes distressed by her sudden inability to concentrate and to remember and she redoubles her study efforts, often staying up late every night, even staying up all night, in an attempt to keep up with her work. In spite of these efforts, she finds it increasingly difficult to maintain her previous caliber of work.

A more chronic type of disturbance is suggested when one sees a girl with average or better intelligence who has a long history of scholastic difficulties, out of proportion to her adequate intelligence. One would think that such a discrepancy would have caused someone to recognize the emotional basis of the difficulties long before. Unfortunately, many youngsters struggle along from grade to grade in school, always being threatened, cajoled, bribed, compared with others, depreciated, but never being understood and helped.

Another rather common type of disturbance occurring in the academic area is often called "examination anxiety." Many students experience tension and some anxiety before examinations. Some students, however, experience very severe disturbances. Panic reactions may make it impossible for the student to remain in the classroom, let alone to write an examination. Sometimes the student's mind may literally go blank every time she is confronted with an examination. Certain students react by turning the anxiety into somatic channels. In this group, severe headaches, nausea and vomiting, abdominal pains, or other symptoms may send the student to bed before every examination. Needless to say, these reactions are all out of proportion to the situation and indicate significant emotional difficulties.

There is another type of scholastic difficulty, which, while less common, deserves inclusion here. Many students find certain subjects more difficult for them than others. Occasionally a student will find a certain subject so distasteful to her or so difficult for her that her reaction to it will actually become phobic. Marked reactions against any particular subject or marked difficulties with a particular subject in an otherwise good student should be open to suspicion. Such instances are often based upon conflicts between the student and one or both parents. For example, a father who has been proficient in mathematics may have pushed the daughter to be interested and proficient in his favorite subject. Her rejection of the subject may indicate deep-seated antagonism to her father.

Finally, when a student develops strong antagonism to a specific teacher one must suspect some underlying emotional problem. This teacher may represent a parent figure to the student. The student may be displacing unresolved hostility to the parent onto the teacher. This can sometimes create serious difficulty for the student. It sometimes signals the beginning of definitive emotional illness.

Social. When a previously active and popular girl suddenly drops out of activities and curtails other social experiences, serious emotional illness is almost always present. The same significance can be applied when a girl who has previously been quiet, reserved, and reticent socially suddenly enters into multiple activities with no judgment as to time involved, effort, or abilities.

Other signs to look for in the social sphere include the following: (1) expression of ideas of inadequacy, failure, inferiority, or worthlessness in a girl who has not previously expressed such ideas or in a girl in whom there is no basis for such ideas, (2) resort to phantasies which are told to others as the truth, and (3) expressions of social thinking which is contrary to the mores of the group. This includes any kind of unusual or unwarranted rebellion against the accepted customs of the group.

There are, of course, many kinds of chronic social maladjustment which do not need enumeration here. All of these difficulties are products of emotional insecurity, and some are signs of definitive emotional illness.

Physical. One of the common outlets for emotional conflicts is in somatic symptomatology. Such physical symptoms may be the only outward sign of the trouble within or may be in addition to other manifestations.

In the group of 2,250 girls surveyed in this study, 391 presented physical symptoms which were functional in nature. The most common was fatigue, which was the principal complaint in 141 girls. Headache was second in order of frequency, occurring in 89 girls. Severe dysmenorrhea was next with 82. Overweight was the complaint in 75, multiple complaints in 52, constipation in 43, insomnia in 37, gastrointestinal symptoms in 26, backache in 24, abdominal pain in 24. Other physical symptoms occurred less frequently.

Persistent physical symptoms without an organic basis should be a definite indication for psychiatric evaluation. Such symptoms may be relatively innocent, being related to some superficial or situational conflict. However, the physical symptoms may be the forerunner of a developing emotional illness of some dimensions. Early recognition of the latter may provide an opportunity to halt the process.

Disciplinary. Behavior problems in adolescent girls are always an indication of emotional maladjustment. They sometimes are an expression of specific emotional illness. Since girls often act out their conflicts in socially unacceptable behavior, it is important to attempt to evaluate such behavior with this in mind.

Stealing is a rather common symptom of serious emotional difficulty. A girl will be caught stealing in the dormitory, or perhaps in a downtown store. Usually she will steal articles for which she has no need or which she could easily buy. When she steals money it is usually not because she needs it. Often these girls will seem to go out of their way to get caught. Most often stealing is a product of feeling unloved and unwanted. It represents an aberrant way of taking what is not given. The girl feels guilty and makes certain of getting caught so that her guilt feelings will be lessened through punishment. There is also a large element of hostility involved in stealing, hostility which may be related to the parents' failure to give love and affection.

From the emotional standpoint, pathological lying is in the same category as stealing. Rebellion against authority, expressed by failure to observe the rules or the laws, is usually an expression of inner resentment to the parents. Cheating is a kind of stealing; it sometimes is an expression of the thought "If my parents don't tell me what I want to know, I will steal it from someone else."

Indiscriminate sexual activity is always evidence of emotional illness. A resentful, disturbed, mixed-up girl will sometimes turn to sexual experience in an effort to find some kind of emotional gratification. This is, of course, a purposeless reaching out for affection and never accomplishes anything positive. It serves to make the girl unhappier and more disturbed and strengthens the feelings of unworthiness which are already present. She proves to herself that she is a "bad girl." Since the sexual experiences are usually unsatisfying, her already-present doubts about her femininity are increased. Girls with such problems can never adjust to the role of wife and mother unless they receive help with these problems before marriage.

Whenever possible, a girl who manifests any type of behavior disturbance should have the benefit of psychiatric evaluation. Often these girls have considerable awareness of their insecurity and quickly respond to the opportunity for well-directed, constructive help with their problems.

Implications of Emotional Illness in Adolescent Girls

When a girl develops emotionally determined symptoms of sufficient severity to cause her to seek medical help, she deserves a careful psychiatric evaluation. There is often a temptation to minimize the emotional aspects of the illness. The girl's parents may not want to hear that their daughter has emotional problems; sometimes the daughter doesn't want to face it either; sometimes the physician doesn't want to face it. Some doctors need to feel that they are omnipotent; they find it difficult to say to the patient that there is an illness present which they do not understand or know how to treat. Many times a doctor finds it easier to brush aside

the facts and to give false reassurance to the patient and to the parents. Or the doctor may find it easy to prescribe phenobarbital, or even placebos, hoping that time will take care of the symptoms.

Although it may be a great disguiser, time is seldom a great healer. The symptoms may disappear, but the underlying problems are not solved. At some later and more undesirable time, symptoms will again appear—symptoms which do not yield to time. Often by then the symptoms may be reluctant to yield to anything.

It is unfortunately true that many young women's marriages are too much the product of their emotional conflicts. In some instances it may be a matter of getting married to escape an intolerable situation at home; in others it may be a futile grasping for security.

In many instances the implications of neurotic marriages are rather subtle; the girl picks a man whose own emotional problems somehow complement hers. A gross example of this kind of occurrence is the girl who marries a man 20 or 30 years older than she. Usually such a girl is actually seeking a father rather than a husband. Many girls with needs related to fathers marry men in whom they see their own fathers. Others, rebelling against their fathers, marry men who seem to be the direct opposite of their own fathers. Another example of the subtlety of the motivating factors in getting married: a girl who rejects her own femininity and has a need to be aggressive and dominating marries a passive, often somewhat effeminate man.

Marriages which are motivated by immature emotional needs often fail. Many which do not fail in the sense that separation or divorce ensues fail because of emotional illness. Many women who become emotionally ill following marriage, childbirth, or the onset of the menopause had distinct emotionally determined symptomatology during their teens which was undiagnosed or untreated. When the woman's life has become complicated in a neurotic marriage, often with children, it becomes much more difficult to extricate her from her neurosis. In addition, as with other kinds of illness, the longer the duration of the illness, the more difficult the treatment.

Frequently one can avert illness and unhappiness in the future by recognizing and treating significant emotional problems in adolescent girls. The implications from the standpoint of preventive medicine are twofold: (1) preventing future illness in the patient and (2) avoiding the unfortunate effects of the patient's neurotic patterns of reaction upon her children.

Indications for Treatment

Every patient must be carefully evaluated as an individual in determining the nature of her illness and the indications for treatment. Accurate evaluation of the total person must always precede any recommendation for treatment. This is just as important in the realm of emotional illness as it is in the area of physical illness.

The stating of specific indications for treatment must always be done with the above qualifications in mind. Certain symptoms and certain patterns of reaction are usually indicative of illness and strongly suggest the need for treatment. Some such indications have been mentioned in the preceding section of this article. The following list of indications for treatment is by no means all-inclusive and is meant to serve as a guide rather than as a measuring rod:

1. Presence of anxiety or fear without adequate reason.
2. Excessive meticulousness.
3. Persistent insomnia.
4. Loss of ability to concentrate in school, together with loss of interest and enthusiasm.
5. Scholastic difficulties out of proportion to the girl's ability.
6. Excessive shyness.
7. Unmanageability and defiance of authority.
8. Exaggerated reactions to sexuality.
9. Psychosomatic illness.
10. Stealing, pathological lying, or excessive drinking.
11. Interpersonal difficulties.
12. Marked dependency needs.

Treatment

Generally speaking, late adolescence is an ideal period in which to utilize the psychotherapeutic approach to emotional problems. The problems and conflicts from the preceding years of emotional growth tend to emerge

rather steadily in the struggle for independence and emotional maturity which crystallizes during these crucial years. There is usually a good deal of flexibility to the personality structure at this time. Also, the individual has not yet become implicated in some of the complex life situations resulting from marriage and parenthood. Motivation to solve problems and to attain maturity and stability is usually good at this age.

The therapy of youngsters in the early years of adolescence is, on the other hand, often very difficult. These girls are often too threatened by treatment to allow themselves to participate. The struggle between the instinctual forces and reality factors is very intensive at this time. The patient is too frightened by the force of her instinctual drives to allow them to be expressed in a treatment situation.

The treatment approach must be highly individualized and based upon careful evaluation of the patient. Psychotherapy based upon a psychoanalytical orientation is the treatment of choice. Whenever a young person can be helped to work through her problems in the specially structured milieu of the psychotherapeutic situation, she will have the best chance of effecting meaningful and lasting changes.

Many times parents will agree that their youngster needs psychotherapeutic help, but will protest that they cannot afford it. They will then proceed to send her to special schools, hire tutors, pay many doctor bills resulting from her functional symptomatology, buy vacations so that she can get rest, and perhaps end up by paying a large sanitarium bill or by supporting her in an immature marriage. Parents will unflinchingly spend money for education, wanting their daughter to go to the best possible school and to have the most possible advantages while there. It is difficult for them to see that when their daughter is emotionally disturbed she will not be able to utilize effectively the educational advantages being offered. Furthermore, it is often difficult for the parents to see that failure to eliminate the emotional problems may be a far greater handicap to the girl than lack of a college education. An investment in security and happiness is always worth while.

A large percentage of adolescent girls with emotional problems are accepting of a psychotherapeutic approach to their problems and do very well in treatment. Girls with schizophrenic reactions requiring hospitalization and insulin or electric shock treatment usually improve and then are able to utilize psychotherapy to work out the underlying problems. The frequency of the treatment interviews and the duration of the treatment vary considerably. Unless the problems are quite superficial, one can expect several months of fairly concentrated treatment to be necessary. In some situations a year or two may be needed by the patient to attain her therapeutic goals.

It is well not to neglect the fact that in some instances treatment will be unsuccessful. Some patients in all age groups do not respond to any type of psychiatric treatment. In the adolescent group those who do not do well are usually those with a long history of withdrawing from the world about them and who now show no depth of feeling and no interest in solving their problems or desire to meet them.

Any physician who wishes to learn more about the emotional problems of adolescents will find it valuable to read *The Adolescent* by Marynia F. Farnham, M. D., Harper and Brothers, 1952.

Summary

1. It is often difficult to differentiate between normal variations in behavior in adolescents and behavior which is psychopathological.

2. Four areas in which to look for signs of emotional disturbance in this age group are: (1) scholastic, (2) social, (3) physical, and (4) disciplinary.

3. The great importance of the preventive aspects of effectively helping these young people is emphasized.

4. The late adolescent period is a highly desirable one from the standpoint of treatability. Some general indications for treatment are noted.

---

153 East Silver Spring Drive.

The Dangers of Codeine Overdosage in Children*

By MAX J. FOX, M. D.,** and EARL JOCHIMSEN†
Milwaukee Madison

IN RECENT years there has been an increase in the use of cough-suppressive mixtures, many of which contain codeine. Our experience at South View Isolation Hospital, Milwaukee, suggests that the possible dangers of such medicaments are not always appreciated by physicians. In the 3 cases described below, codeine had been used to relieve the cough accompanying measles and had led to a serious degree of respiratory depression and convulsions. The cases illustrate the importance of the cough reflex in suspected cases of measles encephalitis and the similarity in symptomatology between measles encephalitis and codeine overdosage.

Codeine, or methyl morphine, was first isolated by Robiquet in 1832, but did not come into general clinical use until 1880. In 1883, Schroeder observed that codeine increases the spinal reflexes decidedly more than morphine, and is, therefore, more liable than morphine to produce convulsions. In his experiments with dogs, Claude Bernard found that a major difference between the actions of codeine and morphine lay in the awakening after large doses of codeine, which is not accompanied by the fright and dementia seen after morphine.[1] In 1933 Barlow[2] showed that animals must be given four times as much codeine as morphine to produce a comparable respiratory depression. Goodman and Gilman[3] note that as the dose of codeine is increased there is no corresponding slowing of the respiratory rate; instead, increased dosages tend to stimulate the brain stem. Grollman[4] states that although both codeine and morphine depress the cough reflex, codeine is the better drug to use for this purpose because cerebral centers are less affected by it. It has generally been accepted that codeine is less likely than morphine to produce addiction.

The following 3 cases, treated at South View Isolation Hospital, illustrate the effects of large doses of codeine in children.

Case Reports

CASE 1—A 2-year-old white boy was admitted on March 23, 1943, from a fire department ambulance which had been called when the child had generalized convulsions at his home. The typical pre-rash symptoms of measles had developed on March 20, and the rash had appeared on March 22. A few days before, his brother, aged 8 years, had been diagnosed by the family physician as having measles. The patient's cough had become particularly bothersome, so his mother had dosed him freely with a cough mixture containing 30 mg. of codeine in 30 cc., which had been prescribed for his older brother. Altogether the child received about 90 cc. of this mixture; *i. e.*, about 90 mg. of codeine. An hour before admission he had started general convulsions. When the fire department was called and gave the child oxygen, the convulsions had ceased.

On admission to the hospital at 9:15 a. m. the patient was reacting only to very painful stimuli; his lips and nails were cyanotic. He had a nasal discharge and a morbilliform rash, and his respiratory rate was 8 to 10 per minute. A provisional diagnosis of encephalitis was made, though codeine intoxication remained a possibility. Treatment consisted of oxygen and 1 ampule of Coramine and 3½ grains of caffeine sodium benzoate intramuscularly. By 10:30 a. m. the patient responded better to stimuli, his color had improved, and his respirations were now 16 per minute. A spinal tap yielded clear fluid under normal pressure, containing no cells and normal on chemical analysis. The patient improved steadily, slept and ate well that evening, and was discharged the next morning.

CASE 2—A 4½-year-old white boy was admitted on June 16, 1952, at 9:10 p. m. with his 2½-year-old brother. (Case 3) Cough, rhinitis, and fever had developed on June 11. A rash appearing on June 14 was diagnosed

* From the Department of Internal Medicine, Marquette University School of Medicine and the South View Isolation Hospital, Milwaukee.

** Associate Clinical Professor of Medicine, Marquette University School of Medicine; and Preceptor, University of Wisconsin Medical School.

† Senior Medical Student, University of Wisconsin Medical School, Madison.

by the family physician as measles. A mixture containing 6 mg. of codeine in 5 cc. was prescribed. The boy had taken about 100 cc. of this mixture throughout the day. On examination the patient was very lethargic, pale, and cyanotic, with irregular respirations varying in rate from 8 to 10 per minute. The nasal and buccal mucosa were slightly injected and there was a morbilliform rash covering the trunk. Each of the pupils was 2 mm. in diameter and reacted sluggishly to light. A tentative diagnosis of measles encephalitis was made, with codeine intoxication as a possible alternate. Urine studies were normal. Blood studies revealed the usual leukopenia with a relative lymphocytosis and a normal sedimentation rate. The spinal fluid contained 3 lymphocytes per cubic millimeter, total protein 13 mg. per hundred milliliters, dextrose 53 mg. per hundred milliliters, and chlorides 694 mg. per hundred milliliters. On fluid, balanced electrolytes, oxygen, and penicillin, the boy's respirations became more regular, his color improved, and he slept quietly. On June 17 he awakened, sat up, smiled, and spoke coherently. His cough returned at 7:30 a. m. He was discharged on June 19 in good condition.

CASE 3—A 2½-year-old white boy was admitted on June 16 at 9:10 p. m. with his 4½-year-old brother. (Case 2) A cough, conjunctivitis, fever, and coryza had developed on June 11. A rash had appeared on June 14; this was diagnosed as measles by the family physician, who prescribed a cough mixture containing 6 mg. of codeine in 5 cc. The patient had taken 100 cc. of this mixture throughout the day of admission and his mother had noted that he was very sleepy. The patient was lethargic and cyanotic, with irregular respirations varying in rate from 7 to 10 per minute. There was a morbilliform rash over the trunk and extremities; each of his pupils was 2 mm. in diameter and reacted very slowly to light. His nasal mucosa and pharynx were injected and his reflexes hypoactive. Measles encephalitis was the working diagnosis. Blood studies revealed the usual leukopenia and relative lymphocytosis with a normal sedimentation rate. Urine studies were negative. Spinal puncture revealed a clear fluid, containing no cells, and under normal pressure. The protein was 11 mg. per hundred milliliters; dextrose 55 mg. per hundred milliliters; and chlorides 702 mg. per hundred milliliters. Treatment consisted

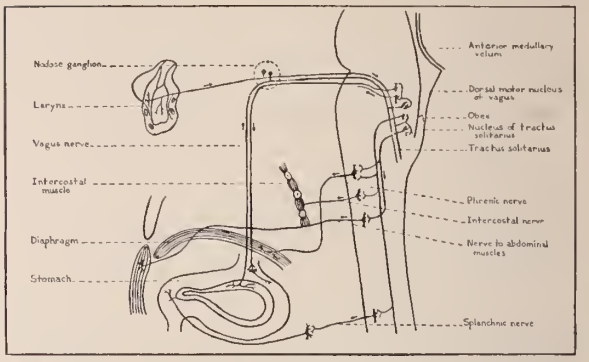


Fig. 1—Reflex mechanism of coughing and vomiting. (Redrawn from "The Anatomy of the Nervous System" by S. W. Ranson.)

of penicillin, fluids, balanced electrolytes, and oxygen. With this treatment the boy's respiration became more regular and his cyanosis had disappeared by 1:30 a. m. on June 17. He began to speak at 4:30 a. m. At 5:30 a. m. he started coughing again. He remained somewhat lethargic until that evening, when he seemed normally alert. His respirations were regular and his color was good. The patient was observed for another day and then discharged in excellent condition.

Discussion

Little has been written recently on codeine intoxication in children,[5,6] though codeine in one form or another is often prescribed to depress the cough reflex when a cough becomes annoying, disturbs rest, or endangers a recent surgical incision. The mechanism of the cough reflex is worth studying so that its importance can be fully realized. The senior author, in a previous paper,[7] describes the process as follows: "The cilia of the mucosa of the trachea and bronchi move in an undulating manner, sweeping tracheal and bronchial secretions towards the mouth. Afferent impulses arising from the irritation of these secretions on the larynx, trachea, and bronchi are transmitted to the brain stem via the vagi. Impulses are then propagated to the motor neurons innervating the muscles of inspiration and expiration. There is a short forced inspiration; the glottis closes; the muscles of forced expiration, especially the abdominal muscles, contract, and intrathoracic pressure increases. Then the glottis suddenly opens, and there is an explosive expulsion of air; thus the cough is initiated in an attempt to remove the irritating substance." (Figure 1)

The cough in measles is a result of the catarrhal inflammation of the respiratory

mucous membranes. Its importance in the pre-rash syndrome of cough, coryza, conjunctivitis, and Koplik's spots need not be stressed. The general feeling, however, is that once the diagnosis of measles has been established, the usefulness of the cough abruptly ceases and it becomes merely a nuisance. In the senior author's experience in treating measles encephalitis, suppression of the cough reflex through involvement of the tractus solitarius indicated the approach of the encephalitis involvement in 74 per cent of his cases.[8] Thus, in cases where the diagnosis of measles encephalitis is entertained, the presence of an intact cough reflex is of the utmost import and should not be recklessly or routinely suppressed by the use of drugs. The tendency to prescribe a cough depressant whenever a cough is troublesome is to be condemned. In every case an attempt should be made to assess the value of the cough before suppressing it. The cough reflex may be an important clinical sign in poliomyelitis as well as in measles. Narcotics should be used only in the very few cases when the value of cough suppression outweighs its inherent dangers.

It is noteworthy that the clinical pictures in codeine intoxication and in measles encephalitis are identical. The senior author reports convulsions in 44 per cent and irregular respirations in 12 per cent of his cases of measles encephalitis.[8] Cerebrospinal fluid cell counts, ranging from 15 to 900 cells per cubic millimeter, certainly rule out the diagnosis of encephalitis in the cases presented here, but the ability of codeine to produce a picture mimicking that of encephalitis should be borne in mind in differential diagnosis. In taking a routine history, therefore, the examining doctor should inquire about previous medication, including cough medicines. The doctor who prescribes a cough depressant must remember that the mixture will probably be placed in the family medicine cabinet to be used whenever a cough occurs in the household, regardless of the age of the affected person. It is the doctor's duty to warn a responsible member of the household that the action of codeine does not stop with cough depression and that the prescription suitable for one age group should not be used for people of ages less tolerant to the drug.

Summary and Conclusions

1. A brief discussion of the pharmacology of codeine is presented with a comparison to the actions of morphine.
2. Three cases of codeine intoxication with respiratory depression are reported in children with measles.
3. The anatomy of the cough reflex is described and its importance emphasized as a danger signal of oncoming encephalitis in measles.
4. The differential diagnosis of measles encephalitis and codeine poisoning may be difficult, and their identical clinical pictures should be borne in mind.
5. The dangers of overdosage with codeine in small children are pointed out. The physician's duty is to see that the parents recognize these dangers and do not use codeine mixtures as a routine family remedy.

(M. J. F.) 324 East Wisconsin Avenue.

REFERENCES

1. Sollmann, T. H.: A Manual of Pharmacology and Its Application to Therapeutics and Toxicology. Ed. 7. Philadelphia, W. B. Saunders, 1948, pp. 235–244.
2. Barlow, O. W.: Comparison of effects of morphine, pantopon, codeine, narcotine, and papaverine on respirations of rats and rabbits, J. Lab. & Clin. Med. 18:785–795 (May) 1933.
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics. New York, The Macmillan Co., 1941. pp. 186–223.
4. Grollman, A.: Pharmacology and Therapeutics. Philadelphia, Lea & Febiger, 1951, p. 100.
5. Cornell, V. H: Codeine poisoning: fatal case from accidental overdose, Ann. Int. Med. 34:1274–1277 (May) 1951.
6. Rascoff, H., Redner, B., and Weinberg, S.: Hycodan (dihydrocodeinone) poisoning: complete recovery following an initial coma of 15 hours in a 3 year old child, J. Pediat. 34:223–225 (Feb.) 1949.
7. Fox, M. J., and Sanders, D. D.: Management of respiratory embarrassment in poliomyelitis, Wisconsin M. J. 46:885–894 (Sept.) 1947.
8. Fox, M. A.: Measles encephalomyelitis. Accepted for publication by A.M.A., Am. J. Dis. Child.
9. Beckman, H.: Pharmacology in Clinical Practice. Philadelphia, W. B. Saunders Co., 1952, p. 475.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The 20th Annual Meeting of the American College of Chest Physicians will be held in San Francisco from June 17 through 20, 1954. Physicians interested in presenting scientific papers on any phase in the diagnosis and treatment of heart and lung disease should send a 100 word abstract, not later than Jan. 1, 1954, to Dr. Edgar Mayer, Chairman of the Committee on Scientific Program, 850 Fifth Avenue, New York 21, New York.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Ten Ways to Make Your Office Work Easier

Life can be much easier and smoother for doctor, office secretary, and patient when the doctor's office follows a few relatively simple rules with regard to the Blue Shield Plan of the State Medical Society.

In the past year, Blue Shield has paid the physicians of Wisconsin more than $2,500,000 for services they have rendered to Blue Shield subscribers and dependents. This means that almost every practicing physician in the state performed some services for Blue Shield members which commanded benefits from the plan. The following easily applied rules will help prevent snarls in bookkeeping and eliminate costly and time-consuming correspondence:

Point I. When the patient first visits the doctor, his secretary should ask the patient whether he is enrolled in Blue Shield. If the patient is a member, the secretary should obtain from him the subscriber's name, code number, group number, and contract number. Be sure the patient supplies the Blue Shield, not the Blue Cross, numbers. If the patient is not sure whether he is covered, the secretary should suggest that he find out and write or telephone this information as soon as possible.

Point II. If there is an opportunity, discuss the financial aspects of the care with the patient. Tell him what he can expect the plan benefits to cover.

Point III. In reporting the services rendered to the Blue Shield Plan on the Physician's Service Report, fill in all items. Be sure to report the code number, contract number, subscriber's name, and group number obtained from the patient's identification card. Many of the reports filed with WPS require further correspondence because these items are neglected.

Point IV. Make a full statement of the diagnosis and the specific treatment or operation rendered.

Point V. For surgical procedures in which there may be a range of payment, depending upon the nature and extent of the incision or the procedure required, full information should be given so that the appropriate payment may be authorized.

Point VI. Sign the PSR. Only the doctor who performs the operation or treatment procedure should sign the Physician's Service Report. If there is more than one physician rendering services on a particular case, each should make out a Physician's Service Report for the services he rendered.

Point VII. When x-ray or anesthesia services are rendered by physicians other than the physician in charge of the case, the physicians performing these services should submit individual Physician's Service Reports. These reports should be submitted as soon as possible after the services have been performed.

Point VIII. In hospitalized cases, complete and return the Physician's Service Report as soon as possible after you receive it from Blue Shield. When surgery is performed outside the hospital, submit the Physician's Service Report as soon as the service has been rendered. Make a notation on the office records of the date on which the report was submitted. This will avoid duplicate reports.

Point IX. Read the manuals and the literature issued by the Blue Shield Plan. Ask questions and invite comments. Review the chief types of problems you have with Blue Shield. Do not hesitate to ask questions.

Point X. Attitudes are important too. Blue Shield is the doctor's plan. Accordingly, the doctor and his office aides should treat prepay patients like all the rest. Don't criticize the plans to the patient. If you have any complaints to make, tell Blue Shield.

MEMO:

Watch the mails about the end of September for the "Physician's Manual." This brochure will explain Blue Shield and guide you and your office personnel in handling Blue Shield claims for benefits.

The Physician and the School Health Program

As It Looks to Your State Board of Health

THE health of the school child has its beginnings long before the child reaches school age. The family-physician relationship throughout the prenatal, infant, and pre-school years is of utmost importance in a child's physical and emotional readiness for school. In this year 1953 the health supervision of infants is a recognized part of everyday practice. Many physicians are encouraging parents to keep their children under health supervision through the preschool years and to bring them in for booster injections for whooping cough, diphtheria, and tetanus and for revaccination at regular intervals. Such continuing supervision brings dividends to children, to parents, to schools.

The medical profession as a whole has not fully realized its opportunities for working with our educational systems in health programs for the child during the 12-year span of the school years. Within this period important growth changes are going on. Children must adjust to new environments, new associations, new independence, and new learning opportunities. It is the period ideally suited to instill in the child an appreciation of health, to help him to assume increasing responsibility for good health practices and health habits which will be important throughout his whole life, and to establish his confidence in his physician and in sound medical procedures.

The physician can contribute a great deal through the health examination and medical appraisal of the school child. He is aware that finding defects is only one phase of a program aimed at the prevention and correction of remedial conditions and the promotion of good health. For this reason your State Medical Society and State Board of Health recommend a health examination of the school-age child in the physician's office, with the parents present. The physician's knowledge of the family and child is often helpful in interpreting physical or mental manifestations of any illness revealed. By explaining his findings and recommendations the physician provides an educational experience which can help to establish a family understanding of the importance of follow-through and sound health principles and practices.

Physicians may tend to underrate the value of their medical report to the school on the individual child under their care. A comprehensive report is of the utmost importance to the school in planning for the full realization of capacities, talents, and abilities of the individual child. His whole academic achievement, his ability to get along with people, and his enjoyment of life often may be influenced by proper interpretation of health problems and special needs.

The need for greater cooperation between medical and educational personnel has long been recognized. This fall the American Medical Association is sponsoring its fourth biennial National Conference on Physicians and Schools in Chicago. Wisconsin held its first similar conference in October 1952. Suggestions and comments reflect the value of such conferences in helping physicians and school personnel to understand each other's problems. There is a very real need for more planning leadership from the medical profession. The State Medical Society's Division on School Health is helping to meet this need. Another forward step would be for local physicians representing their medical societies in matters of school health to assume a more active role on local school planning committees so that routine health services can be set up wisely and special needs met.

Physicians may know little about the school health program in their community unless they have a child or grandchild of school age. A good health program should include the following phases:

1. *Healthful living.* Environmental factors essential for good health, such as good lighting, seating, heating, ventilation, sanitary facilities, elimination of playground and building hazards; promotion of good school lunch programs and elimination of vending machines for candy and soft drinks in the school; broadened participation in physical

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

education; planned noon-hour recreation and recess as a health period; pupil-teacher relations, size of classes, teaching load.

2. *Health services.* Readiness programs before school entrance; pupil health guidance records; health examinations of pupils and teachers; control of illness in school by daily observation of pupils; prompt exclusion on suspicion of illness; immunization and vaccination of pupils and teachers; x-ray and tuberculin testing; and parent education. Distribution of iodine tablets, screening of children for both physical and emotional problems through teacher appraisal and specific checks such as weighing, measuring and vision and hearing checks; plans for periodic dental examination; home visits by the nurse regarding significant health problems after referral by the teacher.

3. *Health instruction.* A curriculum planned to include knowledge on health and disease for the pupil from kindergarten through twelfth grade with emphasis on desirable attitudes and health habits, including nutrition, safety, dental health, preventable disease, family life education and sex instruction, infant care and home nursing, physiology, health habits to maintain health status, consumer health education, community health agencies, and education for moderation; use of authoritative materials, visual aids, teacher approaches, meaningful pupil activities, and class discussion.

More information concerning policies and procedures are available from the State Medical Society of Wisconsin or from the Wisconsin State Board of Health.—AMY LOUISE HUNTER, M.D., *Director, Bureau of Maternal and Child Health.*

THE WISCONSIN DIABETES ASSOCIATION

Physicians interested in diabetes, as well as laymen who have diabetes or are interested in the problem, are encouraged to join the Wisconsin Diabetes Association. An affiliate of the American Diabetes Association, it has a clinical and a lay organization which work together closely. To date, the Association has sponsored camps for diabetic children, scientific meetings for physicians, educational talks for diabetics, and diabetic detection drives. The lay group of the Milwaukee chapter meets frequently under the guidance of physicians and dietitians.

Annual dues for the Wisconsin Diabetes Association are $5.00 for physicians and laymen alike. Included in the dues is a one-year subscription to *Forecast,* a national publication on diabetes. Membership in the American Diabetes Association, including a year's subscription to the journal *Diabetes,* costs $15.00.

Communities in the state are encouraged to form local chapters within the framework of the Wisconsin Diabetes Association. For further information, write the Wisconsin Diabetes Association, % Wisconsin Heart Association, 642 North Fifth Street, Milwaukee, Wisconsin.

NEW LEGISLATION AFFECTING PHYSICIANS LICENSED IN SOUTH DAKOTA

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licensees in that state in the amount of $2.00. The registration takes effect January 1, 1954. If you are licensed in South Dakota and wish to maintain that license by payment of the registration fee, please contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota.

Annual Meeting

MILWAUKEE ★ OCTOBER 6-7-8

Scientific Program Highlights

20 Nationally Famous Physicians as Guest Speakers
Daily Teaching Demonstrations

"Special Emphasis" Programs:

TUESDAY, OCT. 6	WEDNESDAY, OCT. 7	THURSDAY, OCT. 8
Anesthesia	Cardiac and Pulmonary Diseases	Pediatrics
▪	▪	▪
Medicine and Psychiatry	Obstetrics and Gynecology	Radiology
▪	▪	▪
Orthopedics	Pathology	Surgery
		▪
		Ophthalmology and Otolaryngology

Annual Meeting Announcements

STATE MEDICAL SOCIETY of WISCONSIN
Annual Meeting

- REGISTRATION: Secure your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Kilbourn Street. Registration hours: Tuesday and Wednesday: 7:30 a.m.–4:30 p.m.; Thursday: 8:00 a.m.–12:00. *Admittance by badge only.*
- CERTIFIED GUESTS: Medical students and hospital personnel admitted on Thursday, *if previously certified,* or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies admitted by presenting their membership cards.
- DELINQUENT MEMBERS OR NON-MEMBERS: Admitted by payment of $10.00, which will be refunded if full dues are paid through county medical society within six months following Annual Meeting.
- VA AND MD'S IN MILITARY SERVICE: Members of Veterans Administration must be full dues-paying members to be admitted. Those physicians in armed services admitted by presenting certification of current military service.
- TELEPHONE SERVICE: *At Milwaukee Auditorium:* During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to special phones installed at the registration desk. The number is Broadway 1–7720. Calls for Milwaukee doctors should be directed through Physicians Service Bureau (Broadway 1–4131), and they will be transmitted to a special phone in the Auditorium located near the main meeting room. A staff member of the Medical Society of Milwaukee County will be in attendance to receive the calls. *At the Hotel Schroeder:* Delegates can be reached during sessions of the House (Monday, Oct. 5, from 9:30 a.m.–12:00; Tuesday, Oct. 6, from 2:00–4:30 p.m.; and Wednesday, Oct. 7, from 8:30–10:00 a.m.) by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Broadway 1–7250). Those attending luncheons can be reached in the same manner between 12:15–2:15 p.m. each of the three days of the meeting. *If you are attending luncheons, inform your secretary of your schedule, so you can be located promptly if you are to be called.* Give your secretary the name of the round-table leader, and the number or letter of the room where the luncheon will be held.
- RESERVATIONS FOR ROUND TABLES AND DINNER: Reservations for round tables and dinner may be made at registration desk in Milwaukee Auditorium from 8:00–11:00 a.m. Between 11:30 a.m. and 12:15 p.m. each day reservations can be made in fifth floor foyer of Hotel Schroeder.
  If you have left your dinner and luncheon tickets at home, duplicates can be secured at locations noted above. *No one may attend a luncheon or the Annual Dinner without a ticket.*
- SPECIAL LUNCHEONS AND ASSOCIATED EVENTS:

MONDAY, OCTOBER 5
12:30 p.m.: LUNCHEON HONORING E. J. McCORMICK, M.D., PRESIDENT OF THE A.M.A.
For members of the House of Delegates, Officers, Councilors, and invited guests.

TUESDAY, OCTOBER 6
12:15 p.m.: ANESTHESIOLOGISTS (McQuiston Luncheon): Parlor B, Hotel Schroeder
ORTHOPEDISTS (Haggart Luncheon): Parlor A, Hotel Schroeder
PAST PRESIDENTS: Parlor G, Hotel Schroeder
BUSINESS PRACTICES IN MD OFFICES: Room 507, Hotel Schroeder
5:30 p.m.: Reception and Tour of "The Story of Medicine in Art" Exhibit: Milwaukee Art Institute, 772 North Jefferson Street.
Open to all MDs and wives who attend special dinner and program as noted below.
7:15 p.m.: Buffet Dinner and Program in Connection with Art Exhibit: Pfister Hotel

WEDNESDAY, OCTOBER 7
12:15 p.m.: WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY (Collins Luncheon): Parlor A, Hotel Schroeder
WISCONSIN SOCIETY OF PATHOLOGISTS (DeCoursey Luncheon): East Room, Hotel Schroeder
PUBLIC HEALTH PHYSICIANS: Room 507, Hotel Schroeder
MARQUETTE ALUMNI LUNCHEON: Blatz Auditorium
5:30 p.m.: President's Reception: East Room, Hotel Schroeder
For all MDs and wives attending dinner and floor show.
6:45 p.m.: Dinner, Dance, and Floor Show: Ballroom, Hotel Schroeder

THURSDAY, OCTOBER 8
12:15 p.m.: WISCONSIN SOCIETY OF RADIOLOGISTS (Leucutia Luncheon): Parlor C, Hotel Schroeder
SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY: East Room, Hotel Schroeder

- SPECIAL PRE-CONVENTION SCIENTIFIC PROGRAM: Sunday, Oct. 4: *Chest Physicians:* Scientific program beginning at 2:00 p.m. in Ballroom, Hotel Schroeder. Dinner at Hotel Schroeder at 6:00 p.m.
- MEDICAL GOLF TOURNAMENT: The annual Medical Golf Tournament will be held at the North Hills Country Club, Milwaukee, on Monday, Oct. 5. Tee-off time will be at 1:00 p.m., and dinner and presentation of awards at 7:30 p.m. If you have not already made reservation for this event and wish to participate, please contact Mr. A. H. Luthmers at the Medical Society of Milwaukee County, Bankers Bldg., Milwaukee.

Condensed Time Table

SATURDAY, OCTOBER 3

7:00 p.m.: Interim Committee; Milwaukee Athletic Club

SUNDAY, OCTOBER 4

3:00 p.m.: Council Meeting; Club Rooms, Hotel Schroeder
6:30 p.m.: Council Dinner; Club Rooms, Hotel Schroeder

MONDAY, OCTOBER 5

9:30 a.m.: First Session, House of Delegates; East Room, Hotel Schroeder
12:30 p.m.: Luncheon, House of Delegates; Ballroom, Hotel Schroeder
1:00 p.m.: Golf Tournament; North Hills Country Club
3:00 p.m.: Reference Committees
7:30 p.m.: Dinner and Awards; North Hills Country Club

TUESDAY, OCTOBER 6

9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
9:00 a.m.: Reference Committees; Hotel Schroeder
10:15 a.m.: Scientific Sessions; Milwaukee Auditorium
(Anesthesia, Internal Medicine and Psychiatry, Orthopedics)
12:15 p.m.: Luncheons; Hotel Schroeder
2:00 p.m.: General Scientific Session; Milwaukee Auditorium
2:00 p.m.: Second Session, House of Delegates; East Room, Hotel Schroeder
5:30 p.m.: Art Reception; Milwaukee Art Institute
7:15 p.m.: Buffet Dinner in connection with Art Show; Pfister Hotel

WEDNESDAY, OCTOBER 7

8:30 a.m.: Third Session, House of Delegates; East Room, Hotel Schroeder
9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:15 a.m.: Scientific Programs; Milwaukee Auditorium
(Cardiac and Pulmonary Diseases, Obstetrics and Gynecology, Pathology)
12:15 p.m.: Luncheons; Hotel Schroeder
12:15 p.m.: Marquette Alumni Luncheon; Blatz Auditorium
2:00 p.m.: General Scientific Session; Milwaukee Auditorium
5:30 p.m.: President's Reception; East Room, Hotel Schroeder
6:45 p.m.: Annual Dinner, Dance, and Floor Show; Ballroom, Hotel Schroeder

THURSDAY, OCTOBER 8

9:00 a.m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:15 a.m.: Scientific Programs; Milwaukee Auditorium
(Pediatrics, Radiology, Surgery)
12:15 p.m.: Luncheons; Hotel Schroeder
12:15 p.m.: Luncheon and Section Program, Section on Ophthalmology and Otolaryngology; East Room, Hotel Schroeder
2:00 p.m.: Closing Scientific Session; Ballroom, Hotel Schroeder

COUNCIL ON SCIENTIFIC WORK

Members in Charge of Planning 1953 Annual Meeting Program

T. O. NUZUM
Chairman

J. W. GALE
General Program Chairman

P. A. MIDELFART
Director, 1954 Postgraduate Teaching Programs

S. A. MORTON
Chairman, Scientific Exhibits

M. G. RICE
Director, Special Teaching Programs, 1953 Annual Meeting

R. S. BALDWIN
Medical Editor, Wisconsin Medical Journal

J. S. HIRSCHBOECK
Dean, Marquette University School of Medicine

W. S. MIDDLETON
Dean, University of Wisconsin Medical School

OFFICERS

STATE MEDICAL SOCIETY OF WISCONSIN

J. C. GRIFFITH
Milwaukee
President

F. L. WESTON
Madison
Treasurer

G. E. FORKIN
Menasha
Speaker

A. H. HEIDNER
West Bend
Past-President

H. K. TENNEY
Madison
President-Elect

J. W. FONS
Milwaukee
Vice-Speaker

COUNCILORS FOR 1953

R. G. ARVESON
Frederic
Chairman of Council
Councilor, 10th District

S. E. GAVIN
Fond du Lac
Chairman Emeritus

W. H. COSTELLO
Beaver Dam
Councilor, 1st District

T. C. HEMMINGSEN
Racine
Councilor, 2nd District

N. A. HILL
Madison
Councilor, 3rd District

H. E. KASTEN
Beloit
Councilor, 3rd District

E. M. DESSLOCH
Prairie du Chien
Councilor, 4th District

A. H. HEIDNER
West Bend
Councilor, 5th District

A. J. McCAREY
Green Bay
Councilor, 6th District

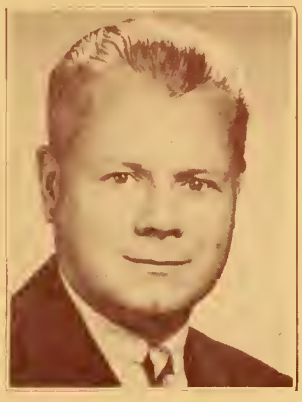
COUNCILORS FOR 1953

J. C. FOX
La Crosse
Councilor, 7th District

J. M. BELL
Marinette
Councilor, 8th District

E. E. KIDDER
Stevens Point
Councilor, 9th District

V. E. EKBLAD
Superior
Councilor, 11th District



W. T. CASPER
Milwaukee
Councilor, 12th District

R. E. GALASINSKI
Milwaukee
Councilor, 12th District

E. L. BERNHART
Milwaukee
Councilor, 12th District

N. J. WEGMANN
Milwaukee
Councilor, 12th District

C. E. ZELLMER
Antigo
Councilor, 13th District

Special *Notice For*

E. J. McCORMICK, M.D.

DELEGATES, COUNCILORS, AND OFFICERS

On Monday, October 5, there will be a special luncheon for all delegates, councilors, officers, and invited guests, with Doctor E. J. McCormick, president of the American Medical Association, as the principal speaker. Arrangements will be made to have representatives of important state associations in attendance, as well as board members of the Medical Auxiliary.

Because of changes in meeting days the following schedule will be followed for meetings of the House of Delegates and related groups:

Monday, Oct. 5

9:30 a.m.: First Meeting of the House of Delegates; East Room, Hotel Schroeder, Milwaukee.

12:30 p.m.: Special luncheon honoring Doctor McCormick; Ballroom, Hotel Schroeder.

3:00 p.m.: Reference Committees. Meetings will be held by all reference committees to organize and to hear delegates and members who wish to appear.

Tuesday, Oct. 6

9:00 a.m.: Reference Committees—continued meetings until 11:00 a.m.

2:00 p.m.: Second Meeting of the House of Delegates; East Room, Hotel Schroeder.

(This meeting will adjourn not later than 4:30 p.m. so that all delegates can join their wives for the Art Exhibit reception at the Milwaukee Art Institute at 5:30 p.m., and the buffet dinner and program at the Hotel Pfister at 7:15.)

Wednesday, Oct. 7

8:30 a.m.: Third Session of the House of Delegates; East Room, Hotel Schroeder.

Hotel Rooms . . .

The Hotel Schroeder has been requested to honor reservations made by Delegates, Officers, and Councilors. If reservations have not yet been made, you are urged to do so immediately. If the Hotel indicates inability to provide accommodations, kindly get in touch with the State Medical Society office before October 1.

PRYDE and DAY

LEJAREN à HILLER

Special Features for MDs and Wives

THE STORY OF MEDICINE IN ART

TUESDAY OCT. 6

The Milwaukee Art Institute, in cooperation with the Boston Store, the Medical Society of Milwaukee County, and the State Medical Society, proudly presents an outstanding art exhibit entitled "The Story of Medicine in Art," consisting of paintings, lithographs, and other expressions of art directly related to medicine. Galleries from all over America have loaned works for this show, which will be featured during the Annual Meeting. On Tuesday, Oct. 6, these special features are provided:

RECEPTION AND SPECIAL SHOWING: At 5:30 p.m., Oct. 6, the Milwaukee Art Institute will hold a special reception for doctors and wives who are attending the buffet supper and special evening program at the Hotel Pfister. The reception will be at the Art Institute, and special tours are arranged between 5:30 and 7:00 p.m.

BUFFET DINNER AND SPECIAL PROGRAM: At 7:15 p.m. there will be a buffet dinner at the Hotel Pfister, with Lejaren à Hiller, New York City, internationally famous photographer and illustrator, as the featured speaker.

ANNUAL DINNER ★ DANCE ★ FLOOR SHOW

WEDNESDAY OCT. 7

Something different! No long speeches! Just fun! The Annual Dinner is planned as a period of relaxation and good fellowship.

STEVE SWEDISH AND HIS ORCHESTRA will play during dinner and provide music for dancing between courses.

50 YEAR CLUB AWARDS: New members of the 50 Year Club will be honored guests, and will receive their awards after dinner.

PROFESSIONAL FLOOR SHOW: As a feature of the program there will be a full hour of high-class professional entertainment, which will conclude the Annual Dinner.

LIMITED ATTENDANCE AT EACH OF THESE EVENTS . . . GET YOUR RESERVATIONS FILED IMMEDIATELY BY WRITING TO THE STATE MEDICAL SOCIETY

HOUSE OF DELEGATES—1953

HOTEL SCHROEDER—Monday, Oct. 5, 9:30 a.m.—Tuesday, Oct. 6, 2:00 p.m.—Wednesday, Oct. 7, 8:30 a.m.
SPEAKER: G. E. Forkin, M.D., Menasha—VICE-SPEAKER: J. W. Fons, Milwaukee

FIRST DISTRICT

Counties	Delegates	Alternates
DODGE	A. B. Kores	L. W. Schrank
JEFFERSON	C. J. Garding	F. A. Gruesen
WAUKESHA	M. J. Werra	W. D. James

SECOND DISTRICT

KENOSHA	D. N. Goldstein	L. H. Lokvam
RACINE	E. J. Schneller	L. J. Kurten
	G. J. Schulz	R. J. Schacht
WALWORTH	E. D. Sorenson	E. D. Hudson

THIRD DISTRICT

COLUMBIA–MARQUETTE–ADAMS	J. H. Houghton	H. A. Winkler
DANE	T. A. Leonard	N. A. Hill
	A. T. Smedal	C. A. Fosmark
	T. W. Tormey, Jr.	Robin Allin
	C. W. Stoops, Jr.	R. F. Collins
	G. C. Hank	O. S. Orth
	A. A. Quisling	W. A. Tanner
GREEN	W. D. Stovall, Jr.	D. E. Mings
ROCK	H. E. Kasten	V. S. Falk
	E. W. Reinardy	K. L. Carter
SAUK	J. F. Moon	J. J. Rouse

FOURTH DISTRICT

CRAWFORD	O. E. Satter	T. F. Farrell
GRANT	J. W. Conklin	K. L. Bauman
IOWA	C. L. White	S. C. Jackson
LAFAYETTE	D. J. Garland	L. J. Unterholzner
RICHLAND	R. E. Housner	D. J. Taft

FIFTH DISTRICT

CALUMET	E. W. Humke	A. C. Engel
MANITOWOC	E. C. Cary	R. G. Strong
SHEBOYGAN	P. B. Mason	F. A. Nause
WASHINGTON–OZAUKEE	E. C. Quackenbush	P. B. Blanchard

SIXTH DISTRICT

BROWN – KEWAUNEE–DOOR	J. W. Nellen	P. F. Dockry
	J. A. Killins	R. M. Waldkirch
FOND DU LAC	H. J. Kief	J. S. Huebner
OUTAGAMIE	G. W. Carlson	H. T. Gross
WINNEBAGO	R. H. Bitter	
	G. R. Anderson	J. P. Canavan

SEVENTH DISTRICT

TREMPEALEAU – JACKSON – BUFFALO	Robert Krohn	F. C. Skemp
LA CROSSE	J. J. Satory	R. W. Rawlow
MONROE	S. D. Beebe	Harry Mannis
VERNON	R. S. Hirsch	T. P. Froehlke
JUNEAU	J. H. Vedner	V. M. Griffin

EIGHTH DISTRICT

MARINETTE – FLORENCE	C. E. Koepp	K. G. Pinegar
OCONTO	H. A. Aageson	D. M. Bailey
SHAWANO	D. S. Arvold	F. W. Henke

NINTH DISTRICT

Counties	Delegates	Alternates
CLARK	M. V. Overman	H. H. Christofferson
GREEN LAKE–WAUSHARA	D. P. Cupery	L. S. Shemanski
LINCOLN	R. G. Baker	K. A. Morris
MARATHON	E. P. Ludwig	D. M. Green
PORTAGE	A. G. Dunn	R. H. Slater
WAUPACA	A. M. Christofferson	F. J. Pfeifer
WOOD	R. E. Garrison	K. H. Doege

TENTH DISTRICT

BARRON – WASHBURN – SAWYER –BURNETT	N. A. Eidsmoe	C. J. Strang
CHIPPEWA	W. C. Henske	J. J. Sazama
EAU CLAIRE–DUNN –PEPIN	R. J. Bryant	R. C. Strand
PIERCE–ST. CROIX	P. H. Gutzler	O. H. Epley
POLK	L. O. Simenstad	V. C. Kremser
RUSK	L. M. Lundmark	Woodruff Smith

ELEVENTH DISTRICT

ASHLAND – BAYFIELD–IRON	J. W. Prentice	J. M. Jauquet
DOUGLAS	Charles W. Giesen	F. W. Reibold

TWELFTH DISTRICT

MILWAUKEE	J. D. Charles	H. E. Bardenwerper
	E. R. Daniels	I. J. Ricciardi
	F. E. Drew	E. P. Bickler
	J. W. Fons	J. E. Conley
	J. G. Garland	J. P. Conway
	J. V. Herzog	M. C. F. Lindert
	S. W. Hollenbeck	P. J. Purtell
	W. J. Houghton	L. R. Schweiger
	G. S. Kilkenny	Joseph Shaiken
	L. P. Stamm	J. M. Sullivan
	C. A. H. Fortier	M. S. Fox
	A. J. Baumann	R. A. Frisch
	J. B. Wilets	R. E. Callan
	R. F. Purtell	D. W. Ovitt
	J. A. Enright	S. L. Chojnacki
	P. J. Niland	A. D. Kilian
	P. E. Oberbreckling	L. A. Weisfeldt
	T. J. Aylward	D. M. Willson
	J. M. Beffel	E. A. Habeck
	S. A. Morton	Richard Foregger

THIRTEENTH DISTRICT

FOREST	E. F. Castaldo	B. S. Rathert
LANGLADE	F. H. Garbisch	C. E. Zellmer
ONEIDA–VILAS	Marvin Wright	I. E. Schiek, Sr.
PRICE–TAYLOR	J. D. Leahy	W. W. Meyer

SECTIONS

Section	Delegate	Alternate
GENERAL PRACTICE	G. E. Forkin	J. A. Grab
INTERNAL MEDICINE	M. A. Hardgrove	R. N. Allin
NEUROLOGY and PSYCHIATRY	E. D. Schwade	Harry Tabachnick
OBSTETRICS and GYNECOLOGY	T. A. Leonard	M. M. Hipke
OPHTHALMOLOGY and OTOLARYNGOLOGY	A. H. Pember	E. J. Zeiss
ORTHOPEDICS	D. W. McCormick	J. E. Miller
PATHOLOGY	Gorton Ritchie	R. S. Haukohl
PEDIATRICS	K. J. Winters	F. J. Mellencamp
RADIOLOGY	W. T. Clark	R. L. Troup
SURGERY	J. M. Sullivan	M. G. Rice

Election of Section Delegates for 1954

Sections will meet on Tuesday, October 6, at 4:30 p.m. in the following rooms in the Hotel Schroeder, to elect delegates for the 1954 House of Delegates. ***(All on Fourth Floor)***

GENERAL PRACTICE: Parlor A
INTERNAL MEDICINE: Parlor B
NEUROLOGY & PSYCHIATRY: Parlor C
OBSTETRICS & GYNECOLOGY: Parlor D
ORTHOPEDICS: Parlor E
PATHOLOGY: Parlor F
PEDIATRICS: Parlor G
RADIOLOGY: Parlor H
SURGERY: Parlor I

(Section on Ophthalmology and Otolaryngology Will Elect Delegate at Section Meeting, Thursday, October 8.)

Special Feature *Daily Oct. 6-7-8*

DEMONSTRATION SCHEDULE

Each Morning
9:00–10:00

Direct, practical teaching in important areas of medicine. One hour of informal instruction, purposely planned for small groups. All teaching programs located on or near stage of Exhibit Hall in Milwaukee Auditorium. Get there early and enjoy this special feature of the program.

ANATOMY: The Department of Anatomy of Marquette University School of Medicine will conduct daily demonstrations on "THE ANATOMICAL BACKGROUND OF THE BRONCHOPULMONARY SEGMENT RESECTION," with Doctors Weston D. Gardner, H. B. Benjamin, and Marvin Wagner as demonstrators. The newer surgical therapy of tuberculosis, pulmonary neoplasia, bronchiectasis, and traumatic conditions which have developed since bronchopulmonary segments have been recognized anatomically and developmentally will be discussed. The anatomy involved will be demonstrated by dissections, models, transparencies, charts, and specimens. The purpose of the exhibit is to give the general practitioner a better understanding of the therapy of the cases he refers for surgery.

OB & GYN: Members of the Wisconsin Society of Obstetrics and Gynecology will conduct daily manikin demonstrations to illustrate special problems of delivery, and when possible will correlate this with outstanding teaching films. Opportunities for questions and audience discussion will be provided.

FRACTURES: This year the Wisconsin Society of Orthopedics will present daily demonstrations on proper application of casts, using medical students as "patients." In addition to the demonstration of plaster of Paris application for fractures of the humerus, the orthopedic section will show some interesting x-rays in the demonstration of intramedullary nailing of the femur. The demonstrations have been arranged under the direction of Joseph R. Stone, M.D., Milwaukee.

CEREBRAL PALSY: The Cerebral Palsy Center, Milwaukee, will present a "live" demonstration with the use of children, occupational therapists, and physicians, who will present methods of evaluation and treatment. The role of the family physician in carrying on methods of treatment on the local level will be stressed. This problem may confront you at any time, so become acquainted with modern methods of treatment and a knowledge of services available to you. Demonstrations under the direction of Raymond Waisman, M.D., Milwaukee, Director of the Cerebral Palsy Center.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present daily discussions on gross pathology, with the use of specimens of greatest interest to the general practitioner. Demonstrations under the direction of Gorton Ritchie, M.D., Milwaukee.

SCIENTIFI

Tuesd

JOSEPH C. AUB
Boston

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES
GROSS TISSUE
ANATOMY DISSECTIONS
OBSTETRICS AND GYNECOLOGY
THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 503 For Full Descriptions)

DAVID A. BOYD, JR.
Rochester, Minn.

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

ANESTHESIA: Walker Hall, Milwaukee Auditorium

Moderator: John Temple, M.D., Milwaukee

9:00: Business Meeting, Wisconsin Society of Anesthesiology.

10:15: **General Anesthesia for the Patient with Cardiac Disease:** John W. Pender, M.D., assistant professor of anesthesiology, University of Minnesota Graduate School, Mayo Foundation.

10:45: **Infant Resuscitation:** William Kreul, M.D., Racine.

11:05: **Anesthesia for Cardiac Surgery:** William O. McQuiston, M.D., instructor in surgery, Northwestern University, and attending anesthesiologist, Children's Memorial Hospital, Chicago.

WILLIAM T. GREEN
Boston

G. EDMUND HAGGART
Boston

ROGRAMS

ctober 6

MEDICINE AND PSYCHIATRY: Juneau Hall, Milwaukee Auditorium

Moderator: Francis L. Hummer, M.D., Madison

10:15: **Psychological Needs of the Medically and Surgically Ill Patient:** David A. Boyd, Jr., M.D., professor of psychiatry, University of Minnesota Graduate School, Mayo Foundation.

(Rogers Memorial Lecture)

10:45: **New Developments in Anticoagulant Therapy:** John Hirschboeck, M.D., dean, Marquette University School of Medicine.

11:15: **The Relationship of Hormones to Carcinoma:** Joseph C. Aub, M.D., professor of research medicine, Harvard Medical School, Boston.

(Lecture sponsored by Wisconsin Division of the American Cancer Society)

ORTHOPEDICS: Kilbourn Hall, Milwaukee Auditorium

Moderator: George L. Thomas, M.D., Janesville

10:10: **Disability Evaluation:** Chester C. Schneider, M.D., Milwaukee.

10:30: **Management of Low Back and Sciatic Back Pain:** G. Edmund Haggart, M.D., chief, department of orthopedic surgery, Lahey Clinic, Boston.

11:00: **Reconstructive Surgery in Poliomyelitis:** William T. Green, M.D., clinical professor of orthopedic surgery, Harvard Medical School, Boston.

(Lecture sponsored by National Foundation for Infantile Paralysis)

Afternoon Scientific Assembly

JUNEAU HALL—MILWAUKEE AUDITORIUM

Moderator: T. O. Nuzum, M.D., Janesville, Chairman, Council on Scientific Work

2:00: **The Treatment of Diseases of the Lymph Nodes:** Ovid O. Meyer, M.D., professor of medicine, University of Wisconsin Medical School.

2:20: **Early Treatment of Poliomyelitis:** William T. Green, M.D., Boston.

2:50: RECESS TO VIEW EXHIBITS

3:30: **Lesions of the Lower Colon:** Paul Shallenberger, M.D., clinical professor of medicine, Hahnemann Medical School, Philadelphia.

4:00: **Complications in Anesthesia Related to Cortisone Therapy:** John W. Pender, M.D., Rochester, Minn.

WILLIAM O. McQUISTON
Peoria, Ill.

JOHN W. PENDER
Rochester, Minn.

PAUL SHALLENBERGER
Philadelphia

SCIENTIFI

Wednesda

JASON COLLINS
New Orleans

ELBERT DeCOURSEY
Washington, D. C.

CHARLES K. FRIEDBERG
New York City

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES

GROSS TISSUE

ANATOMY DISSECTIONS

OBSTETRICS AND GYNECOLOGY

THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 503 For Full Descriptions)

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

CARDIAC AND PULMONARY DISEASES: Kilbourn Hall, Milwaukee Auditorium

Moderator: Francis Rosenbaum, M.D., Milwaukee

10:15: **Medical Management of Hypertension with Particular Reference to Hypotensive Drugs:** Joseph H. Hafkenschiel, M.D., associate in medicine, University of Pennsylvania Medical School, Philadelphia.

10:45: **Electrolyte Disturbances of Heart Disease:** Charles K. Friedberg, M.D., assistant professor of clinical medicine, College of Physicians and Surgeons, Columbia University, New York City.

(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

11:15: **Surgical Management of Unresolved Pneumonia:** William M. Tuttle, M.D., associate professor of clinical surgery, Wayne University, Detroit.

OBSTETRICS AND GYNECOLOGY: Juneau Hall, Milwaukee Auditorium

(Official meeting of the Wisconsin Society of Obstetrics and Gynecology, but all others welcome to attend.)

Moderator: George Stevens, M.D., Wausau, president of the Wisconsin Society of Obstetrics and Gynecology

10:10: **The Present Status of Myomectomy:** Joseph F. Egan, M.D., La Crosse.

ROGRAMS

ctober 7

10:30: **Urologic Complications in Obstetrics and Gynecology:** Lawrence R. Wharton, M.D., assistant professor of gynecology, Johns Hopkins University, Baltimore.

11:00: **Vascular Complications of Pregnancy:** Jason Collins, M.D., assistant professor of clinical obstetrics and gynecology, Tulane University School of Medicine, New Orleans.

11:30: Short Business Meeting of Wisconsin Society of Obstetrics and Gynecology.

JOSEPH H. HAFKENSCHIEL
Philadelphia

PATHOLOGY: Walker Hall, Milwaukee Auditorium

Moderator: Dann Claudon, M.D., Milwaukee

10:10: **The Medicolegal Aspects of Sudden Death:** L. J. Van Hecke, M.D., associate professor of pathology, Marquette University, Milwaukee.

10:30: **The Pathology of Hemorrhagic Fever:** Brig. Gen. Elbert DeCoursey, M.D., director, Armed Forces Institute of Pathology, Washington, D. C.

11:00: **Tumors in Childhood:** Gorton Ritchie, M.D., Milwaukee.

11:20: Short Business Meeting of Wisconsin Society of Pathologists.

WILLIAM M. TUTTLE
Detroit

Afternoon Scientific Assembly

JUNEAU HALL—MILWAUKEE AUDITORIUM

Moderator: Joseph W. Gale, M.D., General Program Chairman, 1953 Annual Meeting

2:00: **Arterial Hypertension as Determined by the Success of Certain Medical or Surgical Procedures:** Joseph H. Hafkenschiel, M.D., Philadelphia.

2:30: **Non-operative Treatment of Stress Incontinence in Women:** Lawrence R. Wharton, M.D., Baltimore.

3:00: RECESS TO VIEW EXHIBITS

3:30: **Thoracic Trauma:** William M. Tuttle, M.D., Detroit.

4:00: **Newer Methods of Diagnosis and Therapy in Office Gynecology:** Jason Collins, M.D., New Orleans.

LAWRENCE R. WHARTON
Baltimore

SCIENTIFI

Thursd

OSCAR J. BECKER
Chicago

9:00: SPECIAL TEACHING PROGRAMS

EXHIBIT HALL—MILWAUKEE AUDITORIUM

One hour of instruction on

FRACTURES

GROSS TISSUE

ANATOMY DISSECTIONS

OBSTETRICS AND GYNECOLOGY

THERAPY OF THE CEREBRAL PALSIED CHILD

(See Page 503 For Full Descriptions)

J. BARRETT BROWN
St. Louis

10:10: SPECIAL INTEREST PROGRAMS

While some are regular meetings of specialty groups, the programs are open to all members of the State Society, and all interested in the subject material are urged to attend.

PEDIATRICS: Walker Hall, Milwaukee Auditorium

Moderator: Niels Low, M.D., Racine

10:10: **Present Status of Epilepsy:** M. G. Peterman, M.D., Milwaukee.

10:30: **The Genetics of Epilepsy:** O. P. Kimball, M.D., chief of medical staff, Doctors Clinic, Cleveland.

11:00: **Status of Immune Globulin:** W. D. Stovall, M.D., director, State Laboratory of Hygiene, Madison.

11:20: Short Business Session of Section on Pediatrics.

HERMANN M. BURIAN
Iowa City

ROBERT M. JANES
Toronto

ROGRAMS

ctober 8

RADIOLOGY: Kilbourn Hall, Milwaukee Auditorium

Moderator: Abraham Melamed, M.D., Milwaukee

10:15: **Comparative Evaluation of Deep Roentgen Therapy and Supervoltage Roentgen Therapy:** Traian Leucutia, M.D., assistant professor of radiology, Wayne University, Detroit.

10:45: **Spinal Cord Tumors:** S. A. Morton, M.D., and Robert Byrne, M.D., Columbia Hospital, Milwaukee.

11:05: **Hodgkin's Disease with Metastasis in Skull:** E. A. Pohle, M.D., and Wayne M. Rounds, M.D., University of Wisconsin Medical School, Madison.

SURGERY: Juneau Hall, Milwaukee Auditorium

Moderator: Frank D. Weeks, M.D., Ashland

10:10: **Diaphragmatic Hernia:** William P. Young, M.D., VA Hospital, Madison.

10:30: **Breast Carcinoma:** Robert M. Janes, M.D., professor and chairman, department of surgery, University of Toronto, Toronto, Canada.
(Lecture sponsored by Milwaukee Division of the American Cancer Society)

11:00: **Homografts, Fresh and Postmortem, as Biological Dressings for Burns:** J. Barrett Brown, M.D., professor of clinical surgery, Washington University Medical School, St. Louis, Missouri.

LUNCHEON AND PROGRAM

SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

EAST ROOM—12:15 P.M.—HOTEL SCHROEDER

Moderator: Gerhard D. Straus, M.D., Milwaukee

1:00: Business Meeting.

1:30: **Evaluation of Diagnostic Methods in the Examination of Neuromuscular Anomalies of the Eye:** Hermann M. Burian, M.D., professor of ophthalmology, State University of Iowa College of Medicine, Iowa City.

2:00: **Radical Surgery in the Treatment of Advanced Carcinoma of the Larynx:** Charles J. Finn, M.D., clinical instructor in otolaryngology, Marquette University, Milwaukee.

2:20: **Occlusion of the Central Retinal Artery:** C. G. Kirchgeorg, M.D., Neenah.

2:40: **The Septum in Relation to Rhinoplastic Surgery:** Oscar J. Becker, M.D., assistant professor of maxillofacial surgery, department of otolaryngology, College of Medicine, University of Illinois, Chicago.

Closing Scientific Assembly

BALLROOM—HOTEL SCHROEDER

Moderator: P. A. Midelfart, M.D., Eau Claire, Member of Council on Scientific Work

2:00: **Rounded Shadows in the Chest:** Robert M. Janes, M.D., Toronto, Canada.

2:30: **Newer Developments in Radiation and Chemotherapy for the Treatment of Cancer:** Traian Leucutia, M.D., Detroit.

3:00: **What the Family Physician Should Know About Emotional Problems of Children:** Milton J. E. Senn, M.D., director, Yale University Child Study Center, Yale University, New Haven, Connecticut.

O. P. KIMBALL
Cleveland

TRAIAN LEUCUTIA
Detroit

MILTON J. E. SENN
New Haven

ROUND TABLE LUNCHEONS—TUESDAY, OCT. 6

All Luncheons at Hotel Schroeder

1. WM. O. MCQUISTON, Peoria: **Pediatric Anesthesia**
2. G. E. HAGGART, Boston: **Further Discussion of the Management of Low Back and Sciatic Back Pain**
3. DAVID BOYD, Rochester, Minn., and OWEN CLARK, Oconomowoc: **Recognition of the Depressed Mental State**
4. W. S. MIDDLETON, Madison: **Newer Drugs and Their Uses**
5. JOSEPH AUB, Boston: **The Metabolism of Bone**
6. F. J. HOFMEISTER, Milwaukee: **Bleeding in the Last Trimester**
7. PAST PRESIDENTS' LUNCHEON
8. J. L. SIMS, Madison: **Problems in the Management of Hepatitis and Cirrhosis**
9. JAMES CONLEY, Milwaukee: **Surgical Problems in the Diabetic**
10. MR. J. P. REVENAUGH (Professional Business Management), Chicago: **Business Practices in the Doctor's Office**
11. JOHN GONCE, JR., Madison: **Problems in Infant Feeding**
12. STURE A. M. JOHNSON, Madison: **Infections of the Hair and Nails**
13. JOHN CURTIS, Madison: **New Concepts in Antimicrobial Therapy in Tuberculosis**

DETACH HERE AND RETURN TO THE STATE MEDICAL SOCIETY, BOX 1109, MADISON, WISCONSIN

Tuesday Luncheon Reservation

[PRICE OF EACH LUNCHEON: $2.50]

Until October 1, reservations for round table luncheons may be made by sending your check to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin.

Reservations for any luncheons which are not filled may also be made at the Annual Meeting. Tickets will be on sale at the Milwaukee Auditorium from 8:00 to 11:00 a.m. and at the fifth floor foyer of the Hotel Schroeder from 11:30 a.m. until luncheon time.

I wish to attend one of these luncheons in the order given.

Tuesday, October 6:

	Number of Luncheon	*Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

* * *

Name _____
(print please)

Address _____

City _____

ROUND TABLE LUNCHEONS—WEDNESDAY, OCT. 7

At Hotel Schroeder Unless Otherwise Noted

1. JASON COLLINS, New Orleans: **Management of Preeclampsia and Eclampsia**
2. C. K. FRIEDBERG, New York: **Management of Intractable Heart Failure**
3. WM. M. TUTTLE, Detroit: **Diagnostic Difficulties in Carcinoma of the Lung**
4. OVID MEYER, Madison: **Newer Drugs and Their Uses**
5. PAUL SHALLENBERGER, Sayre, Pa.: **Peptic Ulcer**
6. LESLIE OSBORN, Madison: **Psychiatric Services in General Hospitals**
7. KENNETH WINTERS, Wauwatosa: **Physician Responsibility in Care of the Premature**

Marquette Alumni Luncheon, Wednesday

If you plan to attend the free luncheon of Marquette Alumni at Blatz on Wednesday do not make reservations for any other luncheon. *Reservations for Marquette luncheon not made through SMS office, so do not list.*

8. C. S. RIFE, Milwaukee: **Problems in the Management of the Acute Abdomen**
9. A. C. EDWARDS, Racine: **The Relationship of Public Health to the Practicing Physician**
10. BRIG. GEN. E. DECOURSEY, Washington, D. C.: **Tissue Reaction to Ionizing Radiation**

DETACH HERE AND RETURN TO THE STATE MEDICAL SOCIETY, BOX 1109, MADISON, WISCONSIN

Wednesday Luncheon Reservation

[PRICE OF EACH LUNCHEON: $2.50]

Until October 1, reservations for round table luncheons may be made by sending your check to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin.

Reservations for any luncheons which are not filled may also be made at the Annual Meeting. Tickets will be on sale at the Milwaukee Auditorium from 8:00 to 11:00 a.m. and at the fifth floor foyer of the Hotel Schroeder from 11:30 a.m. until luncheon time.

I wish to attend one of these luncheons in the order given.

Wednesday, October 7:

	Number of Luncheon	*Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

* * *

Name _____
(print please)

Address _____

City _____

ROUND TABLE LUNCHEONS—THURSDAY, OCT. 8

All Luncheons at Hotel Schroeder

1. MILTON SENN, New Haven: **The Value of the Child Guidance Clinic to the Practicing Physician**
2. J. BARRETT BROWN, St. Louis: **Surgical Repair of Radiation Lesions, Including Those of Atomic Origin**
3. T. LEUCUTIA, Detroit: **Plesiotherapy and Teletherapy with Various Radioactive Sources**
4. FRANCIS D. MURPHY, Milwaukee: **Newer Drugs and Their Uses**
5. T. A. LEONARD, Madison: **Postpartum Management**
6. O. P. KIMBALL, Cleveland: **Epilepsy in Relation to Inheritance**
7. SILAS EVANS, Milwaukee: **Recent Advances in the Experimental Study of Atherosclerosis**
8. R. H. QUADE, Neenah: **Diagnosis and Treatment of Head Injuries**
9. DONALD M. RUCH, Milwaukee: **Occupational Dermatitis—Diagnosis and Management**
10. FRED W. MADISON, Milwaukee: **Hemolytic Anemias and Related Syndromes**
11. JOHN A. SCHINDLER, Monroe: **Psychosomatic Problems in General Practice**
12. F. D. WEEKS, Ashland: **Surgical Problems of the Biliary Tract**
13. LUNCHEON AND SCIENTIFIC PROGRAM OF SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

DETACH HERE AND RETURN TO THE STATE MEDICAL SOCIETY, BOX 1109, MADISON, WISCONSIN

Thursday Luncheon Reservation

[PRICE OF EACH LUNCHEON: $2.50]

Until October 1, reservations for round table luncheons may be made by sending your check to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin.

Reservations for any luncheons which are not filled may also be made at the Annual Meeting. Tickets will be on sale at the Milwaukee Auditorium from 8:00 to 11:00 a.m. and at the fifth floor foyer of the Hotel Schroeder from 11:30 a.m. until luncheon time.

I wish to attend one of these luncheons in the order given.

Thursday, October 8:

	Number of Luncheon	*Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

* * *

Name _____
(print please)

Address _____

City _____

SCIENTIFIC EXHIBITS

Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups

S. A. MORTON, M.D.

The scientific exhibits listed below have been selected for the 1953 Annual Meeting by Dr. S. A. Morton, Milwaukee, a member of the Council on Scientific Work. The exhibits will be open in Bruce Hall of the Milwaukee Auditorium from 8:00 a.m. to 5:00 p.m. on Tuesday, October 6, and Wednesday, October 7, and from 8:00 a.m. to noon on Thursday, October 8.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

S-7a **INCREASE FETAL SALVAGE?**

Obstetrical Departments of St. Joseph's and Milwaukee Hospitals, Milwaukee

Objective: (1) Demonstration of the value of autopsies in all neonatal deaths and stillborn infants; (2) Demonstration of clinical means of obtaining higher fetal salvage.

S-8 **THE USE OF THE SCINTILLATION COUNTER FOR THE MEASUREMENT OF THYROID FUNCTION**

Department of Isotopes of Marquette University School of Medicine, Irving I. Cowan, M.D., Mr. Frank Karioris, Miss Pauline Dolezar, Miss Rita Szejna, and Miss Elizabeth Lawton

The exhibit will consist of the following: (1) Actual exhibit of the scintillation tube and the counting equipment plus a radiation source for demonstration purposes. (2) Description of the tracer technic using the scintillation counter. (3) Demonstration of the advantages of the use of the scintillation counter over other types of equipment. (4) Presentation of several case reports illustrating the clinical application of this method of measuring thyroid function.

S-9, 10 **EARLY AND LATE TREATMENT OF BURNS**

Frank D. Bernard, D.D.S., M.D., Department of Surgery, University of Wisconsin Medical School

The exhibit will offer a pictorial representation of the immediate care of a severely burned patient and a chronological follow-through of dressing technics, indications for skin grafts, and care after grafting has taken place. Also included will be the care of a chronic open burn wound as well as the evaluation and care of contractures and deformities following severe burns.

S-11 **PHYSIO-ANATOMICAL ASPECT OF GASTRIC ULCER FORMATION**

Drs. H. B. Benjamin, Walter Zeit, and Marvin Wagner, and Mr. Eugene Hauschalter, Department of Anatomy, Marquette University School of Medicine

This exhibition presents a physio-anatomical approach to the possible causative factor of gastric ulcers. In this demonstration of our experiments we show the variations which occur in the intragastric temperatures as they are recorded before and during the hunger phase, on patients who have active peptic ulcers, and on the complicated peptic ulcer cases. An intragastric thermapile was employed to obtain these temperatures.

It was noted in our experiments that approximately one-half hour after the patient's desire for food the temperature took a sharp dip to a lower level and shortly after became elevated to its previous or near-previous plateau. It was felt that this reaction took place because the muscular contractions of the stomach arrested the blood flow and led to a dearth of oxygen and the reduction of regional metabolism.

This contention is based on the work done at our institution on the neurovascular mechanism of the stomach, where we have demonstrated that in the stimulated stomach the mucous membrane is kept in a state of anemia because of the shunting mechanism of the vascular bed. This latter work will

also be demonstrated in our exhibit by slides and photographs.

Our demonstration will include live patients. Intragastric temperatures will be recorded and graphs and placards will be used to demonstrate the various curves obtained on various patients.

S–12, 13 SIGMOIDOSCOPY

Paul L. Shallenberger, M.D., and Peter Fisher, M.D., Guthrie Clinic, Sayre, Pa.

Sigmoidoscopy has been an excellent means of detecting early tumor formation and is useful in the recognition of other diseases. The examination is simple and is easily performed by any physician with a minimum of training. We have studied our results in a group of 4,500 consecutive cases examined and the results are tabulated. Some discussion of the various lesions seen with technics of biopsy are included. About 10 per cent of these examinations disclosed tumor formation; 7.6 per cent of these were found on microscopic examination to be benign and 2.7 per cent were malignant. Sixty-five per cent of the cases examined revealed pathological conditions. Many of these could be easily and quickly corrected medically or surgically with complete relief of distress to the patient.

The value of this examination is emphasized and it is urged that it be included as a part of the physical examination, particularly in the over-forty age group.

S–14, 15 NOISE IN INDUSTRY

Meyer S. Fox, M.D., and Paul J. Whitaker, M.D., Milwaukee

This exhibit will deal with the problems relating to hearing impairments resulting from prolonged exposure to high intensities of industrial noise. The physical characteristics of sound and the responses of the human ear to sound will be evaluated. Audiograms taken from case studies found in otologic practice will be shown. These records will illustrate early, moderate, and severe hearing losses and will demonstrate their effects upon hearing and communication. Recommendations for hearing conservation programs in industry based upon findings from current research will be outlined, and various types of ear plugs and defenders will be exhibited. Equipment for evaluating the characteristics of sound (sound level meters and octave band analyzers) as well as instruments for measuring acuity and discrimination ability of human hearing (pure tone and speech audiometers) will be demonstrated.

S–16, 17 THE TOXEMIAS OF PREGNANCY

Wisconsin Academy of General Practice

Although the maternal mortality rate from such causes as sepsis and shock resulting from blood loss has been greatly reduced since the advent of antibiotics and the establishment of blood banks, the toxemias of pregnancy continue to take their toll of fetal and maternal lives.

The key to successful treatment of the toxemias of pregnancy is primarily preventive in nature. Adequate prenatal care should assure every pregnant woman of a gestation uncomplicated by toxemia, especially of the more severe variety. Indeed, the development of severe preeclampsia or eclampsia in such a patient should prompt a reevaluation by the physician of the true adequacy of the care rendered that individual.

S–18, 19 DERMATOLOGIC LESIONS SEEN IN GENERAL PRACTICE

Richard Rowe, M.D., and J. B. Miale, M.D., Marshfield Clinic, Marshfield

The exhibit is a combined demonstration on the part of a dermatologist and a pathologist of the clinical and pathological aspects of the more common skin lesions which a general practitioner might be expected to see in his everyday practice. These will be presented in the form of large transparencies in color, with attached descriptive legends on which the differential diagnosis, histopathology, and treatment of choice will be outlined. Most of the common lesions will be illustrated, as well as a few of the more unusual lesions which are still within the scope of a general practitioner.

S–20, 21, 22 COORDINATED EXHIBITS OF VA HOSPITAL, WOOD, AND MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

1. PAINFUL AFFECTIONS OF THE SHOULDER: Mark W. Garry, M.D.

Considerable confusion exists about the recognition and interpretation of signs and symptoms associated with painful affections of the shoulder. Painful shoulder due to purely local lesions usually is limited to one of three categories: tendinitis, rotator cuff syndrome, or musculotendinous tears. Anatomical charts and printed signs will be used to define the pathogenesis of these disorders. Fuller understanding of the origin and evolution of these disorders is of paramount importance to the early, effective application of definitive treatment.

2. THE VITAMIN A TOLERANCE TEST FOR DIAGNOSIS OF CHRONIC PANCREATITIS: Bruno Peters, M.D., Joseph M. Lubitz, M.D., and Margaret M. Kaser, Ph.D.

The exhibit will summarize our studies of laboratory function tests for chronic pancreatitis. There will be about seven charts arranged in a prefabricated unit. These will show colored photographs of chronic pancreatitis and the various laboratory tests used on our patients. The interpretation of the vitamin A tolerance test will be stressed. The principles of the test will be stated. Charts will illustrate the vitamin A response in normal cases, cases of pancreatitis, and cases of sprue. Representative case histories will be presented.

3. HEMISPHERECTOMY IN THE TREATMENT OF MALIGNANCIES OF THE BRAIN (PHYSIOLOGIC STUDIES): David Cleveland, M.D.

Complete removal of one hemisphere of the brain has been carried out in a series of patients with recurring malignant gliomas of the brain. All of the patients were in the end phase and were extremely poor surgical risks. There has been a fifty per cent survival and one patient with an extremely malignant glioblastoma has survived and has been gainfully employed for four and a half years. Physiologic studies, including intensive sensory examinations, have been made and are

illustrated in stereoscopic slides. An attempt has been made to illustrate hemispherectomy and its effects by stereoscopic viewing.

S-23,24,25 SECTION ON RADIOLOGY

This exhibit will consist of new and recent developments in radiology which are of importance to the field of medicine in general and are of particular importance in the diagnosis of disease by x-ray. The exhibits have been especially prepared for the education of those less familiar with the subject rather than for specialists in radiology.

A list of the specific titles for the exhibits and the contributors are as follows:

1. DISPLACEMENTS OF THE SPINE: A. Melamed, M.D. and A. Marck, M.D., Milwaukee
2. SOFT TISSUE PLACENTOGRAPHY: M. Moel, M.D., Milwaukee
3. CHONDRO-DISPLASIA & RELATED DISORDERS: Donald Babbitt, M.D., Milwaukee
4. LUMBAR SPINE: S. A. Morton, M.D., R. W. Byrne, M.D., and A. Fitzsimmons, M.D., Milwaukee

S-26, 27 COORDINATED EXHIBIT OF STAFF OF COLUMBIA HOSPITAL, MILWAUKEE

1. **CEREBRAL ARTERIOGRAPHY: David Cleveland, M.D., and S. A. Morton, M.D.**
2. **AORTOGRAPHY: Walter M. Kearns, M.D.**
3. **DISEASES OF THE CENTRAL NERVOUS SYSTEM: D. B. Claudon, M.D.**
4. **TUMORS OF THE THYROID GLAND: P. H. Seefeld, M.D.**
5. **DIAGNOSTIC TESTS FOR PAROXYSMAL NOCTURNAL HEMOGLOBINURIA: Winifred Lutsey, M. T. (ASCP)**
6. **TECHNIC OF THE ANTISTREPTOLYSIN TITER DETERMINATION: Marion Tully, M. T. (ASCP)**
7. **MILLIEQUIVALENTS IN MEDICINE: Gorton Ritchie, M.D.**

This exhibit illustrates a number of the diagnostic procedures carried out in various departments of Columbia Hospital.

S-26a THE CONQUEST OF TUBERCULOUS MENINGITIS

Karl E. Kassowitz, M.D., Children's Hospital, Milwaukee, and Muirdale Sanatorium

This exhibit will present in chart form a 10-year study of cases observed at Milwaukee Children's Hospital and Muirdale Sanatorium.

S-28, 29 CANCER RESEARCH AT THE McARDLE MEMORIAL LABORATORY

McArdle Memorial Laboratory and the Cancer Research Hospital, University of Wisconsin Medical School (Sponsored by the Wisconsin Division, American Cancer Society)

The exhibit will describe some of the current problems being studied at the McArdle Memorial Laboratory and at the Cancer Research Hospital, in terms of the technical operations involved and the fundamental questions that are being considered.

S-30, 31 DIAGNOSIS OF LEUKEMIA

Anthony V. Pisciotta, M.D., and Estelle M. Downer, Marquette University School of Medicine, Milwaukee County General Hospital, and the Milwaukee Division, American Cancer Society

The clinical and morphologic aspects of leukemia are illustrated by 8 by 11 enlargements of 35 mm. Kodachrome slides. Emphasis is placed upon the diagnostic aspects of the disease. Physical signs such as lymphadenopathy and splenomegaly are dealt with in one series of prints. The blood and bone marrow picture of all types of leukemia is illustrated by photomicrographs of Wright–Giemsa stained smears. Included in the demonstration are special stains, such as peroxidase stains; the India-ink phagocytic test; and the appearance of cells using supra-vital phase-contrast technic.

Two microscopes will be set up, with examples of the peripheral blood and bone marrow appearance of the various types of leukemia. In addition, the phase contrast microscope will be demonstrated.

S-32 GROWTH IN CHILDREN

Virginia Downes, M.D., Milwaukee Health Department

This exhibit will include charts showing normal growth curves of infants and children of both sexes. It will include pictures showing the measurement technic used, as well as pictures of children in some of the extreme groups in both height and weight as encountered in the child health program in Milwaukee.

S-33 CARDIO-VASCULAR HAZARDS IN BILIARY TRACT SURGERY

John Flinn, M.D., and John Steeper, M.D., Jackson Clinic, Madison

The exhibit will consist of a graphic demonstration of the results of a study of approximately 350 consecutive surgical procedures performed on the biliary tract, specifically emphasizing the cardiovascular complications and hazards. In addition, a series of electrocardiographs, which were taken in the operating room during biliary surgery, will be shown. The electrocardiographic results of distention of the gallbladder, clamping of the cystic duct, and dilatation of the common duct and sphincter will be demonstrated.

S-34, 35 THE USE OF THE CARDIOSCOPE

Wisconsin Heart Association

The Wisconsin Heart Association display will have an electronic cardioscope, a teaching device which was presented to Marquette and Wisconsin medical schools. It reproduces heart sounds through stethophones and projects the sounds on a cathode ray tube. Electrocardiograms can also be projected on the screen. A live subject or tape recordings can be used for the sound and picture.

Medical information produced by the Heart Association will be available to the spectators.

The background panels will describe: 1. the cardioscope, 2. the lay education program

of the Heart Association, 3. professional education, 4. research, 5. community service programs, 6. finances of the Heart Association.

S–36 **AORTOGRAPHY IN PERIPHERAL VASCULAR DISEASE**

James M. Sullivan, M.D., Robert Frisch, M.D., and T. J. Pfeffer M.D., VA Hospital, Wood

This exhibit will consist of case reports in which aortography has been used diagnostically together with a reproduction of the individual aortograph. The various case reports will be in a separate brochure and the reproduction of the aortograph may be viewed in conjunction with this brochure. The technic of aortography will be described and illustrated as will also be the indications for this procedure particularly as related to peripheral vascular disease.

S–37, 38 **TUBERCULOSIS AND PULMONARY DISEASE**

University of Wisconsin Medical School and the Wisconsin Anti-Tuberculosis Association

The exhibit will present research studies on resection specimens of pulmonary tuberculosis following adequate preparation of the patient with chemotherapy. Certain phases of residual tuberculosis, bronchiectasis, and chronic tuberculous bronchitis will be illustrated. (These studies are conducted by the University of Wisconsin and are made possible by a grant given the University of Wisconsin by the Wisconsin Anti-Tuberculosis Association and many of its local associations.)

A portion of the exhibit will be devoted to helpful information for the general practitioner on the diagnosis, treatment, and control of tuberculosis.

EXHIBITS FACING STAGE AND ON STAGE

S–14a **SPINAL CORD TUMORS**

S–20a **Henry M. Suckle, M.D., Madison General Hospital, Madison (Exhibit located near center of hall, at end of S–14 and S–20, facing the stage)**

The exhibit is to indicate the diagnosis, both clinical and myelographic, of spinal cord tumors; the surgical treatment; and also the various histologic types.

On Stage **ACETABULAR PROSTHESIS**

(Near Fracture Demonstration) **Frederick G. Gaenslen, M.D., and Herman C. Schumm, M.D., Milwaukee**

The exhibit of the acetabular prosthesis demonstrates the use of a new type of prosthesis designed to mimic the acetabulum. It was designed specifically with the treatment of a heretofore unsolved problem: namely, central protrusion of the acetabulum. It has been used in two cases of this type and some of the complications encountered are illustrated.

The prosthesis is also adaptable for use in cases of fracture of the acetabulum and arthroplasty of the hip besides the use for which it was originally designed.

ANNUAL MEETING WISCONSIN CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Milwaukee, Sunday, October 4, 1953

1:00 p. m. **Registration and Viewing of Exhibits:** 5th Floor

2:00 p. m. **Scientific Program:** Crystal Ballroom: 5th Floor

Electrocardiographic Problems in Daily Practice: A. Helmuth, M. D., Chicago, Illinois

Granulomatous Lung Disease: Joseph M. Lubitz, M. D., Milwaukee

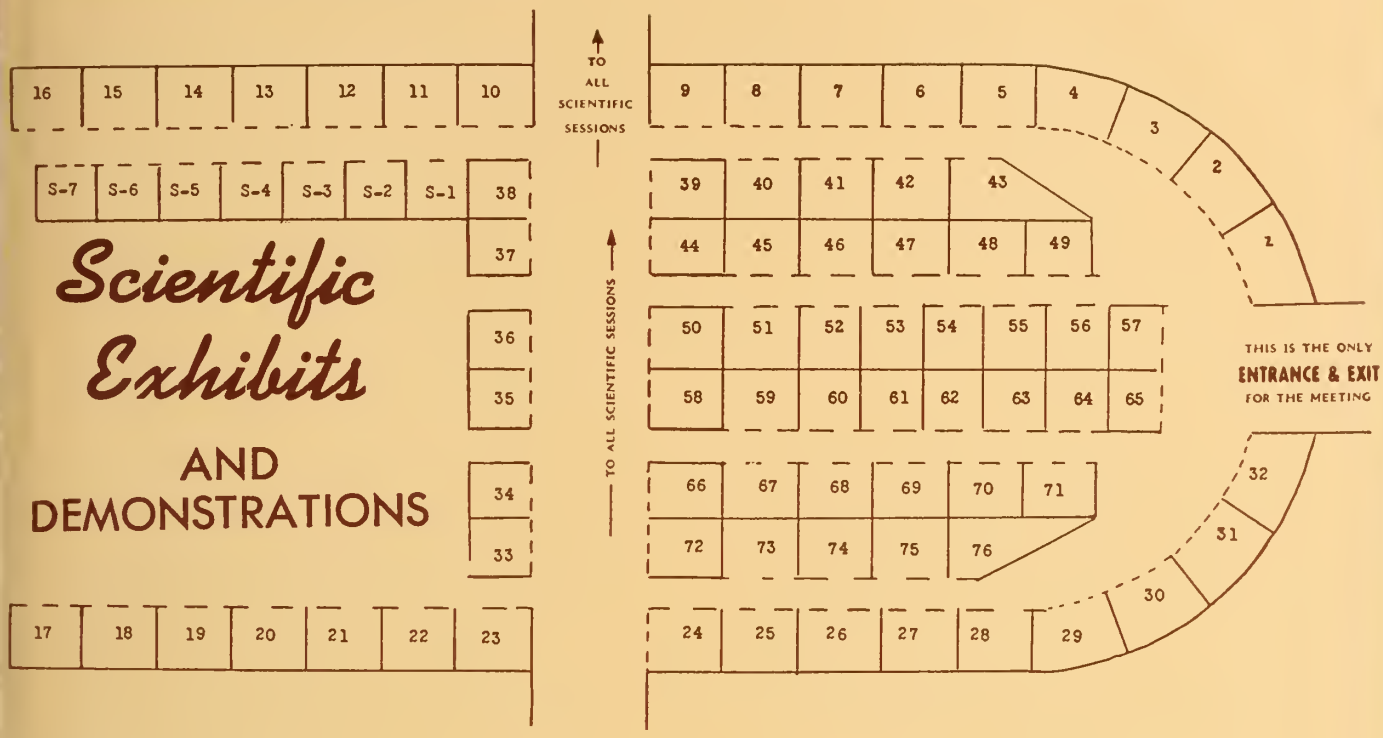
Surgical Treatment of Mitral and Aortic Stenosis: Alfred Goldman, M. D., Los Angeles, California (Motion Pictures)

Inhalation of Dyhydrostreptomycin Dust in the Treatment of Diseases of the Respiratory Tract: Mary Karp, M. D., Edward E. Avery, M. D., et al., Chicago, Illinois

Diseases of the Trachea: Kenneth C. Johnston, M. D., Chicago, Illinois (Motion Pictures)

6:00 p. m. Dinner: Club Rooms, 3rd Floor

Address: **Palliative Treatment of Inoperable Bronchogenic Carcinoma:** Edgar Mayer, M. D., New York, New York



TECHNICAL EXHIBITS

Booth	Company and Products

37 Abbott Laboratories, North Chicago, Ill.

Abbott will display *Sulestrex Piperazine* tablets for the control of symptoms of the climacteric. *Sulestrex* is a pure, odorless, and tasteless compound which is rapidly hydrolyzed in the body. It provides rapid control of menopausal symptoms with an extremely low incidence of side effects. *Sulestrex* is an absolutely pure, crystalline estrogen, chemically standardized for unvarying hormonal activity. Because *Sulestrex* is absolutely pure, it can never impart an odor to the breath or perspiration. The pure inorganic salts of estrone sulfate are combined with piperazine to form a stable, water-soluble, crystalline salt. It is as effective estrogen therapy as it is presently possible to prescribe.

54 A. S. Aloe Company, St. Louis

Visit Booth 54, where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Stecline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches, and advanced design—all in new decorators' colors.

17 Americana Corporation, Chicago

All members and guests of the State Medical Society of Wisconsin are invited to visit Booth 17 to inspect the new 1953 edition of the *Encyclopedia Americana* and the 40th anniversary edition of the *Book of Knowledge*.

Booth	Company and Products

73 American Hospital Supply Corporation, Evanston, Ill.

The American Hospital Supply Corporation will exhibit Baxter intravenous solutions, including *Travert*, the new invert sugar solution providing twice as many calories as dextrose in the same infusion time; Baxter blood transfusion and plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions; and blood and plasma bottles.

68 Ames Company, Inc., Elkhart, Ind.

Apamide, brand of N-acetyl-p-aminophenol, is a new direct-acting analgesic and antipyretic, offering prompt prolonged relief of pain and reduction of fever.

Apromal, brand of N-acetyl-p-aminophenol and acetylcarbromal, combines the direct analgesic-antipyretic action of *Apamide* with the gentle sedative action of acetylcarbromal.

Ictotest, our new diagnostic tablet test for detection of urine bilirubin, will be demonstrated.

66 Ayerst, McKenna & Harrison, Limited, New York

We take great pleasure in extending a cordial invitation to all physicians attending the Annual Meeting of the State Medical Society of Wisconsin to visit Booth 66, where literature and information on *Antabuse*, *Premarin*, and *Exorbin* will be available. Representatives will be pleased to discuss new developments

Booth — Company and Products

with you and answer any questions you may have concerning the various products in our line of prescription specialties.

75 Baby Development Clinic, Chicago

The Baby Development Clinic offers you suggestions for helping your OB patients as well as their babies. *For the expectant mother*—carefully selected LeMonde abdominal and Anne Alt breast supports; Materna Cream to lubricate and ease the stretching skin; and Dial Soap to keep her clean-smelling and -looking. *For the infant and small child*—Evenflo bottles, nipples, and formula method booklets; Tattle Toe Shoes (with the open tongue and visible growth line); Tru-last socks with scientific square toes.

55 The Baker Laboratories, Inc., Cleveland

You are cordially invited to visit our booth, where medical service representatives will be glad to discuss with you the clinical application of *Baker's Modified Milk* and *Varamel*, two outstanding products that are making new progress in successful infant feeding.

32 Barr X-Ray Company, Inc., Milwaukee

The members of our organization will be at our usual place, first booth to your left as you enter the Exhibit Hall, to greet our many friends of the Medical Society of Wisconsin. To be eligible for the prizes to be awarded be sure to register at our booth—the first to your left as you enter the hall.

74 Beech-Nut Packing Company, New York

The Beech-Nut Packing Company will again display its fine variety of strained and junior baby foods. In addition we are proud to present an innovation in the form of a *4-ounce* box for the cereals. This has been done for the convenience of mothers and to insure an always fresh product for the baby.

45 Benson Optical Company, Minneapolis

The latest in ophthalmic instruments and supplies will be exhibited. Your attendance at our display is invited.

S-7 House of Bidwell, Inc., Milwaukee

67 Bilhuber–Knoll Corp., Orange, N. J.

The written prescription bespeaks the physician's treatment of the patient. The medicinal chemicals of Bilhuber–Knoll Corporation merit your study and use in your daily practice. These prescription chemicals will be on display at Booth 67: *Bromural*—sedative, mild hypnotic; *Dilaudid*—analgesic, cough sedative; *Metrazol*—analeptic, tonic; *Octin*—antispasmodic; *Quadrinal*—antiasthmatic; *Tensodin*—coronary insufficiency; and *Valoctin*—sedo-spasmolytic.

38 The Borden Company, Prescription Products Division, New York

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display will be the complete line of Borden infant formula products for every feeding purpose or preference. If you're encountering hyper-irritability or excoriation, you'll be interested in *Bremil*, a formula patterned on breast milk. If you suspect milk allergy in some of your patients, you'll find the answer in *Mull-Soy*, leading hypoallergenic food. For premature infants, or for digestive disturbances demanding low fat and high protein, *Dryco* provides an ideal, flexible formula base. And if your preference is for liquid products, you'll want the latest facts about *Biolac*.

46 Brooks Appliance Company, Chicago

The Brooks Appliance Company will exhibit and describe in detail the technic of applying combination pressure bandages. The moist, medicated Primer Bandage and the Dalzoflex Elastic Adhesive Bandage, which are used in treating leg ulcers and phlebitis, will be shown. Elastic stockings, the Nulast Elastic Crepe Bandage, and surgical instruments will also be displayed.

56, 76 Brown and Williamson Tobacco Corporation, Louisville

Booth 56—KOOL (mildly mentholated) Cigarettes are particularly desirable for smokers who have sensitive or irritated throats. Willie the Penguin has an interesting message and a useful souvenir for each member who visits the KOOL exhibit.

Booth 76—The exclusive health-guard filter tip in the king-size VICEROY Cigarette provides beneficial protection to the smoker. A demonstration and explanation of its unique advantages will be of real interest to all those concerned.

39 Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

Polysporin, Polymyxin B-Bacitracin Ointment, will be featured at the Burroughs Wellcome booth. *Polysporin* gives broad spectrum antibacterial action, resistance to it rarely develops, and it rarely sensitizes. Information will also be available on *Aerodrin*, an intranasal solution which affords decongestion without stimulation and broad spectrum antisepsis.

24, 25 Camel Cigarettes, New York

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette, which outsells all other brands by many billions of cigarettes per year.

71 Carnation Company, Los Angeles

The Carnation Company cordially invites you to visit Booth 71, where you will see a series of translites on our canning and sterilization process. Carnation medical specialists will explain our sole processing and give you reasons why Carnation Milk deserves consideration as your first choice in infant feeding formulas.

58 Ciba Pharmaceutical Products, Inc., Summit, N. J.

Ciba's exhibit (Booth 58) features two new agents for more effective management of hypertensive disorders—*Regitine*, for simple and accurate diagnosis of hypertension produced by pheochromocytoma, and *Apresoline*, an agent of choice for gradual sustained lowering of blood pressure. You are invited to visit the Ciba booth for literature on *Regitine* and *Apresoline*.

SS-2 Coca-Cola Company, Milwaukee

S-6 Contour Chair Company, Milwaukee

We most cordially invite you to stop at Booth S-6 to sit and relax in the genuine Contour Lounges on display. Our representative will be happy to tell you of the advantages of the

Booth — Company and Products

five sizes, six positions, and the anatomically correct design of these wonderful Lounges. You will quickly see how this Lounge will benefit your patients and gain their cooperation in accepting the inactivity of a prolonged rest regimen.

SS-5 Fellows Medical Manufacturing Co., Inc., New York

Felo'ral Capsules, the only, the first non-barbiturate antispasmodic sedative in soft gelatin capsules, will be featured. *Felo'ral Capsules* (pink and white) contain chloral hydrate plus a fixed ratio of the naturally occurring belladonna alkaloids. *Fellows Chloral Hydrate Capsules,* available in 3¾ grain and 7½ grain, the effective and safe sedative and hypnotic without "hangover"—without gastric distress—will also be shown together with other Fellows products.

8 H. G. Fischer & Co., Franklin Park, Ill.

In Booth 8 the H. G. Fischer Company will display modern, low-priced, efficient x-ray and physical therapy equipment, including FCC-approved diathermy machines. Your visit will be welcomed and appreciated. Interesting demonstrations gladly given—no obligation.

72 C. B. Fleet Company, Inc., Lynchburg, Va.

The C. B. Fleet Company cordially invites you to stop at Booth 72 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each hundred cubic centimeters 48 Gm. of sodium biphosphate and 18 Gm. of sodium phosphate. Over the years Phospho-Soda (Fleet) has won discriminating preference by thousands of physicians because of its controlled action . . . its freedom from undesirable side effects . . . and its ease of administration. There is only one Phospho-Soda (Fleet).

1 General Electric Company, X-Ray Department, Milwaukee

The General Electric Company, X-Ray Department, is exhibiting the latest models in their electromedical line—the Model F Inductotherm and the DWB Cardioscribe. The Model F Inductotherm features built-in electrosurgical facilities, improved output, crystal-controlled frequency, and facilities for use of four types of electrodes. The DWB Cardioscribe, direct-writing electrocardiograph, features a new case for easier portability and operation, and a chest lead selector switch which enables the user to take up to 30 leads without changing electrodes.

40 Gerber Products Company, Fremont, Mich.

Gerber's concentrated meat base formula is *new.* It is prepared to replace milk in the allergic infant's diet. It will help assure a well-fed and happy baby. Your Gerber detailman looks forward to showing you this important infant food. He also invites you to examine our complete line of baby foods. Up-to-date baby care booklets are available for your office . . . complimentary, of course.

S-4 H. J. Heinz Company, Pittsburgh

What's new at the Heinz exhibit?—(1) Strained orange juice, strained cream of tuna, pre-cooked rice cereal, strained banana custard pudding, junior macaroni and cheese, and junior chicken noodle dinner. (2) New spill-proof plastic tumbler for weaning. (3) Literature for your patients: "Strained Foods for your Baby's Diet," "Junior Foods for Older Babies," "Recipe Magic Using Heinz Strained and Junior Foods," and "Facts about Foods" (includes caloric values and analyses of carbohydrates, protein, fat, calcium, sodium, iron, and vitamins). (4) For office use: "Nutritional Data."

70 Hoffmann–La Roche, Inc., Nutley, N. J.

You will find three products featured in the Roche display: *Asterol,* a new, practically odorless antifungal agent for ringworm of the skin, hair, and nails; *Gantrisin,* a more soluble, single sulfonamide which provides a wider antibacterial spectrum in systemic and urinary infections; and *Roniacol,* a new, well-tolerated vasodilator which is useful in vascular disorders and in some cases of angina pectoris.

33, 34 Hurley X-Ray Company, Milwaukee

While attending your State Meeting we will be happy to welcome you to our booths. Several items of interest manufactured by the Picker X-Ray Corporation and the Burdick Corporation—leaders in the field of x-ray and physical medicine—will be shown. Our field organization will be in attendance to discuss your needs with you.

29, 30 Karrer Company, Milwaukee

Our outside representatives will welcome their friends at Booths 29 and 30, where the Karrer Company will display Hamilton, Allison, and Ritter medical furniture, and Liebel–Flarshelm short wave and electrosurgical units, ultraviolet and infra-red lamps, portable and cabinet sterilizers, autoclaves, basal metabolors, suction and pressure units, physicians' bags, centrifuges, diagnostic and surgical instruments, Vim syringes and needles, and many other new items.

4 Kremers–Urban Company, Milwaukee

Welcome to the K. U. booth. New medications featured will be *Kused* for sedation all along the line; *Salimeph-C* for relief of the pain-spasm cycle in rheumatoid arthritis and related conditions. New clinical data on *Kutapressin* will be available.

S-2, 3 Laabs, Incorporated, Milwaukee

Over 50 years' service to the medical profession has been given by this distributor of physicians, hospital, and industrial medical supplies, pharmaceuticals, laboratory supplies, surgical instruments, and equipment.

28 Lakeside Laboratories, Inc., Milwaukee

Lakeside representatives will be on hand at the Lakeside Laboratories booth to discuss *Neohydrin, Mercuhydrin Sodium,* and other Council-accepted products, as well as research in various fields.

64 Langer Laboratories, Inc., Milwaukee

Once more we've got a handy booth
To greet each man, and handsome youth,
Once more we greet you with a line
That you'll agree is super-fine.
So make a note—pay us a call,
We're here to greet you—one and all.

69 Lederle Laboratories Division of the American Cyanamid Company, New York

You are cordially invited to visit our exhibit in Booth 69, where you will find representatives who are prepared to give you the latest information on Lederle products.

Booth — Company and Products

44 Eli Lilly and Company, Indianapolis
You are cordially invited to visit the Lilly exhibit in Booth 44. Antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly salesmen will welcome your questions about these and other recent therapeutic developments.

42 J. B. Lippincott Company, Philadelphia
J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

21 Lov-e' Brassiere Company, Hollywood, Calif.
The Lov-é Brassiere Company will present their highly specialized line of breast supports. This company manufactures 18 separate and distinct models in a range of more than 500 sizes. All of these brassieres are custom fitted by highly trained brassiere experts. Mrs. Mern Ruelle, special consultant in charge of the exhibit, will be glad to explain how prescription instructions are followed to meet the patient's individual requirements.

35 M & R Laboratories, Columbus, Ohio
Your *Similac* representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of *Similac* in infant feeding. They have for you the latest Pediatric Research Conference Reports. Current reprints of pediatric nutritional interest are also available.

18 Maico of Madison, Madison
A display of audiometers, auditory training units, stethetrons, and hearing aids including materials demonstrating the use of transistors in modern electronic equipment will be shown at Booth 18. The display is designed to give the general practitioner and the specialist a better understanding of diagnostic and remedial materials for the hard of hearing.

26 Mead Johnson & Company, Evansville, Ind.
In Booth 26 Mead Johnson & Company will feature *Dextri-Maltose,* the carbohydrate of choice in infant formulas; *Lactum,* Mead's complete liquid formula; and *Olac,* Mead's complete powdered formula. Also to be featured will be *Natalins,* the new smaller prenatal capsule; vitamin products for infants and children, *Poly-Vi-Sol, Tri-Vi-Sol,* and *Mulcin;* and the four *Pablum Cereals.* Representatives in attendance will be glad to furnish information regarding these products.

13 Medco Products Company, Tulsa, Okla.
The *Medcolator* Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low-volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

6 Medical Protective Company, Fort Wayne, Ind.
The know-how in defense and proved protection against loss that have made the Medical Protective Company pre-eminent in the professional liability field through more than half a century now add new luster to the Company's time-tested individual plan of professional protection in the face of severe underwriting difficulties prevailing elsewhere. Authoritative answers to questions arising out of the doctor-patient relationship may be obtained at Booth 6 from the Company's representative, who has had the special training and long experience that prove so advantageous in this field.

23 Medico-Mart, Inc., Milwaukee
Our display will consist of Hamilton equipment, Raytheon Microtherms, Castle and American sterilizers, surgical instruments, and Council-accepted pharmaceuticals.

65 The Wm. S. Merrell Company, Cincinnati, Ohio
Tace—a new drug for the hormonal containment of prostatic carcinoma.

Tace (chlorotrianisene) possesses certain peculiar attributes not common to other estrogens. In the dosages used in experimental studies, *Tace* apparently induced less pituitary or adrenal hyperplasia than other estrogens. This one fact—lack of apparent effect upon the pituitary-adrenal — has caused considerable interest among urologists treating carcinoma of the prostate with estrogens.

19 Miller Surgical Company, Chicago
The Miller Surgical Company, Booth 19, will show the Miller Electro-scalpel. This unit cuts, desiccates, fulgurates, coagulates, and can be used for most delicate work up to light major surgery. A complete office unit, it is portable and weighs 19 pounds with cords, handles, foot switch, and accessories such as insulated snares and smoke ejector. Also on display will be Miller's complete line of diagnostic equipment consisting of illuminated otoscopes, ophthalmoscopes, eyespuds with magnet, transillumination lamps, headlights, vaginal speculum, Gorsch operating scopes and stainless steel proctoscopes of all sizes with magnification, suction tubes, and grasping forceps.

SS-3 The Milwaukee Company, Milwaukee
Information on investments of special interest to physicians will be available. Our representatives will be pleased to discuss with you various types of investments which can be secured through this reliable Wisconsin company.

50 V. Mueller & Company, Chicago
V. Mueller & Company will again display a complete line of surgeons' instruments. Many new items in the thoracic and cardiovascular line will be shown.

20 The National Drug Company, Philadelphia
The National Drug Company cordially invites you to visit their booth. *Dimethylane, AVC Improved,* and *Resion* will be displayed. *Dimethylane* is a new, versatile compound for controlling symptoms of dysmenorrhea, the menopause, and associated tension states. *AVC Improved* is effective against an extremely wide range of vaginal tract infections. *Resion* offers a more rapid and more complete control of diarrhea in infants and adults; also for controlling nausea of pregnancy, food poisoning, and enteric infections.

11 A. R. Nechin Company, Chicago
On exhibit will be the entirely new Jones Air Basal. This is a new concept in metabolism testing. No oxygen tanks or capsules are required. Oxygen from room air is used in making the metabolic determination. Also shown will be the PC_3 Cardiotron, a new model of the original direct-recording electrocardiograph, and the Teca low-voltage generators for nerve and muscle testing and stimulation.

27 John Nichols, Inc., Milwaukee
The Gray Audograph dictating machine is to the dictating machine field what the jet plane

Booth — Company and Products

is to aviation. More and more the specialist and the general practitioner alike are finding that any means of easing their work load is virtually a necessity. The Gray Audograph, using a vinylite plastic disc, is just that aid. It is the maximum in performance but offers the lowest initial cost, the lowest cost of operation, and the lowest cost of service. The audograph can be seen in Booth 27.

49 Parke, Davis & Company, Detroit

A cordial welcome awaits you at the Parke–Davis booth. Members of our medical service staff will be on hand to greet you and discuss any of our products in which you may be particularly interested.

12 H. E. Pengelly X-Ray Company, Milwaukee

The H. E. Pengelly X-Ray Company has been in the x-ray business since 1908, only 13 years after the discovery of x-ray by Professor Roentgen. We are distributors for Standard X-Ray Company, Continental X-Ray Company, all x-ray film manufacturers, and all accessory equipment makers. We also distribute physical therapy and hydrotherapy equipment.

48 Pet Milk Company, St. Louis

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

31 Chas. Pfizer & Co., Inc., Brooklyn

You are cordially invited to visit the Pfizer booth, where you will find well-informed representatives who will be happy to supply you with information and answer any questions about Pfizer products. Terramycin dosage forms will be the feature attraction of the Pfizer exhibit.

3 Philip Morris & Co., Ltd., Inc., New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration to show the difference in cigarettes will be made on smokers at the exhibit.

62, 63 Physicians & Hospitals Supply Company, Inc., Minneapolis

The Physicians & Hospitals Supply Company of Minneapolis invites you to visit Booths 62 and 63 to examine the latest in medical equipment, including the new FCC-approved shortwave diathermy, a complete display of Swedish stainless steel instruments, Ulmer Pharmaceuticals, and many other new items of interest. Our representatives will be present at all times to discuss your requirements.

16 Professional Business Service, La Crosse

"Business efficiency experts for the medical office" is the description applied to this service by clients. Representatives will be at the booth to greet doctors and explain the scope of service available.

53 A. H. Robins Company, Inc., Richmond, Va.

Featured prescription specialties at the Robins booth are the outstanding antitussive-expectorant *Robitussin,* the analgesic-sedative *Phenaphen* and *Phenaphen with Codeine,* and the effective skeletal-muscle relaxant *Mephate.* Robins medical service representatives will be in attendance at all times to discuss these and other Robins products with physicians attending the State Medical Society of Wisconsin convention.

43 Roemer Drug Company, Milwaukee

14 J. B. Roerig and Company, Chicago

Members of the State Medical Society of Wisconsin are cordially invited to visit the booth of J. B. Roerig and Company. Professional service representatives will be on hand to welcome all interested visitors.

S-1 Rystan Company, Inc., Mount Vernon, N. Y.

Rystan features Council-accepted *Chloresium Ointment* and *Chloresium Solution* (Plain), containing the purified, non-toxic, water-soluble derivatives of chlorophyll. In the topical treatment of wounds, burns, ulcers, and dermatoses these therapeutic chlorophyll preparations promote the growth of healthy granulation tissue, relieve itching and irritation, and deodorize malodorous lesions. Reprints of published clinical and laboratory studies on *Chloresium* therapy are available, and representatives will be pleased to discuss specific applications of these preparations.

52 Sandoz Pharmaceuticals, New York

It is with a great deal of pleasure and pride that we invite you to visit our exhibit at the forthcoming convention. Our representatives will gladly welcome you to Booth 52.

57 W. B. Saunders Company, Philadelphia

A few of our new books of special interest, published since last year, are Graybiel and White's Electrocardiography in Practice; Duncan's Diseases of Metabolism; Gross' Surgery of Infancy and Childhood; Sheldon, Lovell, and Mathews' Clinical Allergy; Lewis' Practical Dermatology; Bakwin and Bakwin's Clinical Management of Behavior Disorders in Children. Our standard books such as Cecil–Loeb's Textbook of Medicine; Mitchell–Nelson's Pediatrics; Dorland's Dictionary; and the Medical and Surgical Clinics of North America, will, of course, be included. Ask about our new Clinics—The Pediatric Clinics of North America.

9 Schering Corporation, Bloomfield, N. J.

Members of the State Medical Society of Wisconsin and their guests are cordially invited to visit the Schering exhibit, where new therapeutic developments will be featured. Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

10 G. D. Searle & Company, Chicago

You are cordially invited to visit Searle at Booth 10. Members of our medical service staff will be on hand to answer any questions pertaining to Searle products of research. Featured will be newer dosage forms of *Banthine,* the standard anticholinergic therapy; *Dramamine,* for the control of nauseas; *Alidase,* for improved absorption of fluids; and *Metamucil,* for the physiologic correction of constipation and other gastrointestinal dysfunctions.

Booth — Company and Products

60 Sharp & Dohme, Incorporated, Philadelphia

Research data on oral penicillin therapy is featured at the Sharp & Dohme technical display. The exhibit endeavors to justify reliance on oral penicillin for the therapy of the majority of penicillin-treatable infections, excluding fulminating diseases requiring hospitalization. A resumé of the intestinal bacteriostatic agents *Sulfasuxidine* and *Sulfathalidine* completes the exhibit. Expertly trained personnel will be present to discuss these observations.

5 Smith, Kline & French Laboratories, Philadelphia

The Smith, Kline & French booth will feature *Spansule* sustained release capsules—the revolutionary new oral dosage form. Just one *Spansule* capsule, taken on arising, provides a uniform supply of medication throughout the day. Thus, *Spansule* capsules offer you three advantages: (1) smooth, uniform action, (2) prolonged therapeutic effect, and (3) convenient once-a-day dosage.

51 E. R. Squibb & Sons, Long Island City, N. Y.

New Squibb products, and new brochures of useful interest to you on products already introduced, will be featured at Booth 51. As in former years, your Squibb representative cordially invites you to visit the Squibb booth.

61 The Upjohn Company, Kalamazoo, Mich.

The importance of cortisone is expanding as clinicians discover new applications for it. The Upjohn Company is justly proud of its part in the development of cortisone and in its discovery of new production methods. It is our aim to make cortisone available to ever-increasing numbers. Competent representatives welcome your inquiries and discussion.

41 U. S. Standard Products Company, Woodworth

We will be on hand, as in former years, to greet our friends, displaying our biologicals and pharmaceuticals and ready to explain our formulas.

7 U. S. Vitamin Corporation, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble—a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research Laboratories.

On display will be three pharmaceutical firsts: *Vi-Syneral Vitamin Drops* — multivitamins in drops solution: *Vi-Syneral Injectable*—multivitamin parenteral solution; and now *Vi-Aquamin*—aqueous vitamins and minerals in a single capsule.

The exhibit will also feature original, complete lipotropic therapy—*Methischol*—the combination of five proved lipotropic agents: B_{12}, choline, methionine, inositol, and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes, and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

22 Vaisey Bristol Shoe Company, Inc., Monett, Mo.

Jumping Jacks are not corrective shoes. Representatives will display worn-out *Jumping Jacks* to show how the doctor may use them as a diagnostic aid. Representatives will also show and explain the adhesive tape wedge devised by Dr. H. A. Sincock of Superior for pretesting and determining the amount of wedge needed to correct each foot.

Booth — Company and Products

47 Varick Pharmacal Company, New York

E. Fougera & Company, Inc., a division of the Varick Pharmacal Company, Inc., cordially invites physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

SS-1 Walden Industries, Inc., New York

Walden Distributors, Inc., will show the versatile "Quick-Clix" clinical photographic projection bulb and Strobe outfits equipped with remote control, automatic pre-set aperture, and shutter operating mechanism for finer color and finer black and white photography. We will also show our new "Walco" units for simple, standardized, daily routine clinical photography. The units are extremely low priced to induce the widespread use of clinical photography.

SS-4 Warner–Chilcott Laboratories, New York

Research and sales personnel will welcome an opportunity to discuss two important cardiovascular agents: *Methium*, an oral hypotensive, and *Peritrate*, a vasodilator for prophylaxis in angina pectoris.

15 Westinghouse Electric Corporation, X-Ray Division, Baltimore

2 White Laboratories, Inc., Kenilworth, N. J.

Gitaligin, which has been described as a ". . . digitalis preparation of choice," will be on display at Booth 2. White's representatives will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of this and other outstanding White products.

36 Winthrop–Stearns, Inc., New York

Winthrop–Stearns invites you to visit Booth 36, where the following products will be featured: *Mebaral*, sedative and antiepileptic, produces tranquillity virtually without drowsiness; *Telepaque*, the new, highly effective, and well-tolerated oral cholecystopaque medium, gives denser, clear-cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts; *Levophed*, the true vasoconstrictor hormone of the adrenal medulla, for the maintenance of blood pressure in shock and other acute hypotensive states; *Isuprel*, new potent bronchodilator for sublingual use and inhalation.

S-5 Wyeth Laboratories, Philadelphia

Wyeth will exhibit *Plavolex*, 6 per cent solution of dextran, a highly efficient *pla*sma *vol*ume *ex*pander. For use in shock or wherever the circulatory blood volume is to be increased, *Plavolex* assures satisfactory colloid osmotic properties, satisfactory viscosity, and prompt onset as well as prolonged action. *Plavolex* eliminates: (1) the problem of aging (seen with whole blood), (2) delay (as in melting frozen plasma), (3) the danger of virus hepatitis. *Plavolex* is sterile, ready for immediate use with the disposable infusion kit.

Also featured are various dosage forms and combinations of *Bicillin*, the new penicillin compound. See *Bicillin* Oral Suspension, palatable, stable, ready-to-use; and *Bicillin* Injection, giving two-week blood levels on a single injection, ideal in treatment and prophylaxis.

59 Zimmer Manufacturing Company, Warsaw, Ind.

AUXILIARY CONVENTION PROGRAM 1953

MRS. B. P. CHURCHILL
Milwaukee
Convention Chairman

25th Anniversary Meeting

State Journal Photo

MRS. REBECCA C. BARTON
Madison

Monday, October 5

P. M.

4:00 to 6:00 Registration, Fifth Floor, Hotel Schroeder

6:00 Board of Directors' Dinner, English Room, Hotel Schroeder

State Officers, State Chairmen, County Presidents and Presidents-Elect, and Past State Presidents

Hostess—Mrs. R. M. Kurten, Racine, Immediate Past-President

(Dress optional)

Tuesday, October 6

A. M.

8:00 Registration, Fifth Floor, Hotel Schroeder

9:30 Formal opening of the Twenty-Fifth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Pere Marquette Room, Hotel Schroeder

Mrs. M. J. Reuter, President, presiding

Invocation—The Very Reverend Edward J. O'Donnell, S.J., President, Marquette University

Pledge to Flag—Mrs. A. W. Hammond, Beaver Dam

Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association—Mrs. A. W. Hammond, Beaver Dam

Presentation of Convention Chairman, Mrs. B. P. Churchill, Milwaukee

Presentation of President-Elect, Mrs. C. R. Pearson, Baraboo

Address of Welcome—Mrs. P. L. Callan, President of the Auxiliary to the Medical Society of Milwaukee County

Response—Mrs. C. R. Pearson, Baraboo

Roll Call—Mrs. S. A. M. Johnson, Madison

Minutes of the twenty-fourth meeting—Mrs. S. A. M. Johnson, Madison

Convention Rules of Order—Mrs. R. E. Fitzgerald, Milwaukee

Address of the President—Mrs. M. J. Reuter, Milwaukee

Reports of Officers

President-Elect—Mrs. C. R. Pearson, Baraboo

Vice-President—Mrs. George Ridout, La Crosse

Recording Secretary—Mrs. S. A. M. Johnson, Madison

Corresponding Secretary—Mrs. R. D. Champney, Milwaukee

Treasurer—Mrs. C. M. Creswell, Kenosha (Including report of Auditor)

Parliamentarian—Mrs. R. E. Fitzgerald, Milwaukee

Reports of County Presidents of 1952–1953 (Time limit—2 minutes)

New Business

Credentials and Registration—Mrs. W. F. Grotjan, Milwaukee

P. M.

1:00 Luncheon in honor of County Presidents, Ballroom, Hotel Schroeder

Guest—Dr. LaVera Pohl, Director, Milwaukee Art Institute

Speaker—Mrs. Rebecca C. Barton, Madison, Director, Governor's Commission on Human Rights

5:30 Reception and "Medicine in Art" Exhibit at Milwaukee Art Institute

7:15 Buffet Supper for Doctors and Wives, Hotel Pfister

MRS. LEO J. SCHAEFER
President, A.M.A.
Auxiliary

Wednesday, October 7

A. M.

8:00 Registration, Fifth Floor, Hotel Schroeder

9:30 General Session, Pere Marquette Room, Hotel Schroeder
Mrs. M. J. Reuter, President, presiding
In Memoriam—Mrs. R. E. McDonald, Milwaukee
New Business
Convention Courtesy Resolutions—Mrs. G. B. Ridout, La Crosse
Convention Announcements—Mrs. J. W. Fons, Milwaukee
Report of Nominating Committee—Mrs. F. J. Cerny, Fond du Lac
Election of Officers
Installation of Officers—Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the American Medical Association
Presentation of President's Pin—Mrs. M. J. Reuter
Inaugural Address—Mrs. C. R. Pearson
Credentials and Registration (final report)—Mrs. W. F. Grotjan

A. M.

11:00 Post-Convention Board Meeting, Pere Marquette Room
Mrs. C. R. Pearson, presiding
Workshop for County Presidents, Officers, and Chairmen
Mrs. C. R. Pearson, presiding

P. M.

1:00 Anniversary Luncheon and Style Show, Wisconsin Club
In honor of Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the American Medical Association
Mrs. C. R. Pearson, presiding

. . . *Time to shop and visit the Exhibits of the State Medical Society at the Auditorium* . . .

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Hotel Schroeder

6:45 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

MRS. M. J. REUTER
Milwaukee
President

Officers and Chairmen 1952-1953

MRS. C. R. PEARSON
Baraboo
President-Elect

Officers 1952-1953

President ---------- Mrs. M. J. Reuter, Milwaukee
President-Elect ------ Mrs. C. R. Pearson, Baraboo
Vice-President ------ Mrs. G. B. Ridout, La Crosse
Recording Secretary-Mrs. S. A. M. Johnson, Madison
Corresponding Secretary
----------Mrs. R. D. Champney, Milwaukee
Treasurer -------- Mrs. C. M. Creswell, Kenosha
Past-President -------- Mrs. R. M. Kurten, Racine
Parliamentarian - Mrs. R. E. Fitzgerald, Milwaukee

Committee Chairmen

Nominating ------ Mrs. F. J. Cerny, Fond du Lac
Archives -------- Mrs. L. D. Quigley, Green Bay
Finance ---------- Mrs. R. S. Pelton, Markesan
Today's Health ---- Mrs. R. T. Schmidt, Green Bay
Public Relations -- Mrs. H. W. Christensen, Wausau
Legislative ---------- Mrs. N. A. Hill, Madison
Bulletin ---- Mrs. E. M. Dessloch, Prairie du Chien
Organization -------- Mrs. C. R. Pearson, Baraboo
Press and Publicity ---- Mrs. R. M. Kurten, Racine
Convention ------ Mrs. B. P. Churchill, Milwaukee
Nurse Recruitment ---- Mrs. V. S. Falk, Edgerton

THE MEDICAL FORUM

COMMUNITY ENROLLMENT TRIED IN MANITOWOC COUNTY

DR. SARGENT RESIGNS AS MEMBER OF HEALTH RESOURCES ADVISORY GROUP

Milwaukee, Aug. 4.—Dr. James C. Sargent, Milwaukee, has resigned as a member of the Health Resources Advisory Committee of the Office of Defense Mobilization, and the National Advisory Committee to the Selective Service System.

In making known his resignation, Dr. Sargent stated "For many months now, I have been aware of the fact that these very frequent absences from my office are affecting my career as a physician in a profound and I fear, perhaps a somewhat permanent way. Despite my great interest in all that we have been doing, I am sure you understand that my one real love is the personal care of sick people, and I can't help but hold my practice above all else."

It was with great reluctance that Dr. Sargent's resignation was accepted by President Eisenhower, Mr. Flemming, director of the Office of Defense Mobilization, and the committee. Their regret was expressed in the following resolution set forth in a letter from Dr. Howard Rusk, chairman of the Health Resources Advisory Committee:

"I cannot adequately express how deeply appreciative I am of all that you have given of your experience, knowledge and yourself to the work of our committee during the past two years. No one has made a greater contribution or a greater sacrifice.

"I would consider the situation intolerable if you did not agree to continue on as a consultant. Not only will we all be able to continue the close bonds of friendship that have developed through the years, but also to lean heavily on you for advice and support.

"I know I speak for all the committee and I express a profound gratitude for all you have done."

Dr. Sargent has agreed to remain as a consultant, and will be available on certain occasions in this capacity.

DR. JAMES C. SARGENT

State Statute on Auto Accident Reporting Is Improved by Change

Madison, Aug. 10.—Thanks to the 1953 Legislature, the state statute in regard to reporting auto accidents now makes $100 the minimum figure for accident reporting and for the safety responsibility provisions.

The reporting limit had been raised to $100 from $50 in 1951, but the limit on security provisions under the responsibility law had been left at $50.

Judgments over $100 which remain unsettled for longer than 60 days must be certified by the court to the motor vehicle department for suspension of operator's license until the judgment is paid. Accidents leading to death, injury or property damage totaling $100 also must be reported to local authorities.

★ For news of an important development in Selective Service, see Page 532.

Manitowoc, Aug. 25.—The first of three experimental community enrollment programs for Blue Shield-Blue Cross took place, starting in mid-August, in Manitowoc County.

This program was authorized by the State Medical Society's Commission on Prepaid Plans at its June meeting.

Its primary purpose is to offer Blue Shield surgical-medical protection and Blue Cross hospital coverage to persons who heretofore have not been able to purchase them because of their employment at places where there are not enough employees to form a "group." A secondary purpose is to contact eligible groups which do not have Blue Shield-Blue Cross protection and offer them an opportunity to enroll.

The Wisconsin Physicians Service "A" and "B" contracts were offered. Both include coverage for surgery, medical care, maternity care, anesthesia and x-ray. The Blue Cross comprehensive contract was offered in conjunction. The offer was unique in that people who formerly were only eligible for non-group coverage were given the opportunity of obtaining maternity benefits through the community enrollment plan.

Applications were subject to underwriting requirements and persons who could not meet them will not be covered.

The campaign began August 7 with newspaper and radio advertising. Many possible subscribers were contacted by telephone. Prospects who could not leave home were invited to send in coupons which could be clipped from the newspaper. On August 17, enrollment booths were opened in Manitowoc and Two Rivers, which were maintained through August 22. A booth was opened at the Manitowoc County Fair on August 19.

Prior to this time, the cooperation of the Manitowoc County Medical Society and the local hospitals had been solicited, and en-

(Continued on page 532)

SMS CONDUCTS SCIENTIFIC ACTIVITIES FOR MEMBERS

A member of any organization to which he consistently pays dues is prone to ask himself, from time to time, "What am I getting for my money?" This is the first of a series of articles which explain how the State Medical Society serves the physicians who are its members.

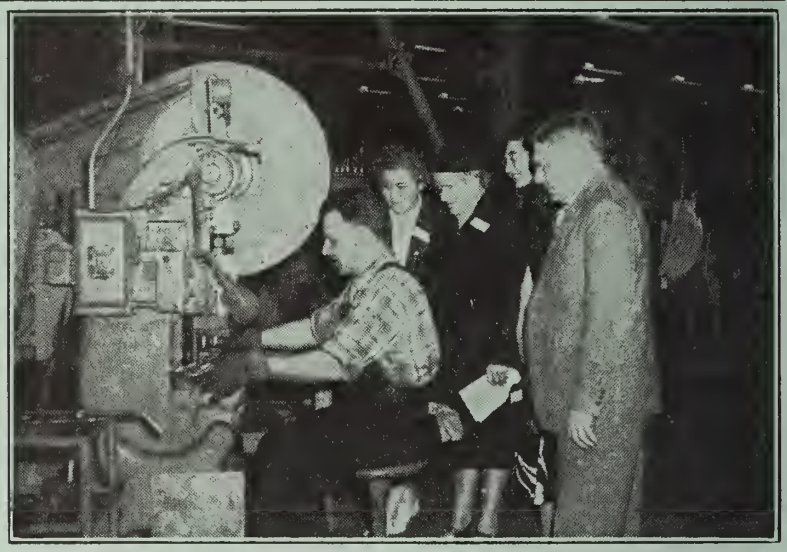
Scientific activities are among the most important of the State Medical Society's functions. According to the society's purpose, as stated in its constitution, it is its duty "to extend medical knowledge and advance medical science . . . . so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease."

To carry out this statement of its purpose, the society conducts two major projects for the further education and instruction of its own members. It also sees to it that the physicians in the state assume a position of leadership in many matters concerning the health of the state as a whole.

Meeting Vast Project

The most ambitious scientific project of the society is the Annual Meeting. To it are brought outstanding authorities in various specialties from all parts of the country. They lecture, provide demonstrations, and in general acquaint Wisconsin physicians with new techniques and methods of treatment in their fields. There will be twenty at the October meeting.

The arrangement of this meeting involves so much detail work that it takes up a third of the time of one staff member and at least half of the time of his assistant. First, speakers are carefully chosen by the physicians who make up the society's Council on Scientific Work. Then there is endless correspondence with the speakers, the panel members for discussion groups, the hotels and the auditorium. Arrangements must be made for demonstration equipment, for loud-speakers, movie screens, projectors and the like. Three days of smoothly running meetings result.



PHYSICIANS ATTEND AN INDUSTRIAL HEALTH CLINIC

Postgraduate teaching programs are conducted out in the state during the year to serve the physician who cannot get away from his practice for more than a few hours at a time. Seventeen of these clinics were held between January 13 and June 25 of this year.

Physicians living in and near the medical centers of Milwaukee and Madison have access to good training without leaving town, so these areas are purposely avoided and clinics scheduled for such widely dispersed communities as Shawano, Eau Claire, Fond du Lac, Neenah, Stevens Point, Siren and Minocqua. Several clinics were held in southern Wisconsin also.

Operated by SMS

Though the expenses of this program are shared with the society by the State Board of Health, the Wisconsin Division of the American Cancer Society and the Wisconsin Heart Association, all arrangements and publicity are carried out by the medical society's staff.

In hopes of lowering still further the maternal death rate in Wisconsin, the Division on Maternal and Child Health of the State Medical Society's Commission on State Departments is conducting an intensive scientific study of all the facts connected with every maternal death in the state.

Each report of a death is studied by a special committee. The material for their study is prepared by physicians who conduct interviews with attending physicians and review hospital records. Then the data is prepared by members of the medical society staff so that the names of the patient, physician, hospital and locality are all deleted. Each case is studied and a confidential report of the committee's findings is sent back to the physician who attended the case. In cases where some change in hospital procedure might have improved the situation, a report goes to the hospital chief of staff also.

At the end of the year, a compilation of the findings of the study committee will be presented to Wisconsin physicians in the Medical Journal.

Since the end of World War II, the society, in cooperation with the Industrial Hygiene unit of the State Board of Health, and the State Board of Nursing, has been working to improve the knowledge of physicians of the hazards in industrial plants.

This has been done by setting up "Industrial Health Clinics" which are organized tours of certain factories followed by addresses on appropriate topics. In the course of the tour, all possible sources of danger or injury are pointed out to visiting physicians along with explanations of what industry is doing to guard against these dangers. This gives the physician who may be handling work-

men's compensation cases a chance to become better acquainted with the industrial problems in his part of the state. The types of plants so far covered have been heavy machinery and farm implement manufacturing plants, paper factories, meat packing houses, toolmaking shops and ship yards.

The problem of hearing loss as the result of exposure to constant noise in an industrial plant is looming large in the industrial health picture. Recognizing this, the State Medical Society is cooperating with the Wisconsin Council of Safety in a series of Hearing Conservation Clinics being held in September and October. There is likelihood of more claims for hearing loss appearing under workmen's compensation, and it will be necessary for physicians to assess such claims properly, as well as to treat the workers effected.

Backs Cancer Society

In the field of cancer, the medical society gives promotional assistance to the Wisconsin Division of the American Cancer Society and its cancer diagnostic teaching clinics. These are "wet" clinics, with live patients used to illustrate to the general practitioner the newest methods of diagnosis of certain types of cancer. The clinics planned for the coming October will deal with uterine cancer, lung cancer, cytologic diagnosis and lesions of the mouth.

Various Councilor Districts throughout the state have scientific meetings occasionally, and the State Medical Society arranges programs and secures speakers for them.

Surveys Schools

A survey was made to determine how many of Wisconsin's schools have regulations requiring examination of teachers and other school personnel to insure their being free of tuberculosis. This was done under direction of the Division on Tuberculosis and Chest Diseases of the society's Commission on State Departments.

The Division on Maternal and Child Welfare is starting a series of pilot studies on neonatal deaths in larger hospitals, all details of which will be carried out through the society office.

A booklet entitled "Code of Necropsy" was produced this year by the society. It involved considerable interviewing of pathologists, hospital administrators and funeral directors and was designed to iron out difficulties among these various groups concerned with autopsies.

Approximately 40 per cent of the medical society's membership attends the annual meeting each year. The postgraduate clinics are estimated to draw about 40 per cent of the membership exclusive of Milwaukee and Dane county members. An attendance of about 100 can be counted upon for each Industrial Health clinic held outside of Milwaukee county. These clinics in Milwaukee county usually draw about 200.

State Medical Society officers and staff receive many expressions of appreciation from the physicians who receive the benefit of the various scientific services. To present at least one opportunity each year for every Wisconsin physician to increase his knowledge in his field and his effectiveness in his community is the desire of the State Medical Society.

Eleven Civil Defense Teams Prepared; Stockpiling Goes on at Camp Williams

Madison, Sept. 1.—Seven of the eight mobile medical teams for civil defense estimated as that area's need have been set up by the Brown-Kewaunee-Door County Medical Society.

Captains for the teams in this area include Drs. G. B. Merline, DePere; C. S. Bolles, Bernard Kulkoski, John Goelz, E. R. Killeen, J. F. McDermott, and R. J. Rose, all of Green Bay. Deputy Captains are Drs. Bernard Waldkirch, De Pere; T. S. Burdon, Donel Sullivan, J. E. Halloin, G. R. Stauff, L. C. Miller and J. E. Dettmann, all of Green Bay.

Chippewa Ready

Two teams in Chippewa county which are lined up are headed by Dr. E. J. Hatleberg and Dr. W. C. Henske, Chippewa Falls. Their deputies are Drs. C. A. Kemper and William Janc, also of Chippewa Falls.

The Green county team headed by Dr. Nathan E. Bear, Monroe, is fully manned and has had a "practice run." Dr. C. E. Baumle, Monroe, is his deputy.

Stockpiling of civil defense supplies continues at Camp Williams. Litters and cots are stored there, along with other emergency equipment. There will be $39,500 worth, all told, with the Federal government and the state government each paying half. $100,000 will be spent for plasma, which is being acquired at the rate of 350 units a month.

Hospitals are making preparations to receive disaster casualties, and transportation is being arranged to bring patients in.

"Refresher" field exercises for radiological monitors are being scheduled for fall months. Team captains having replacement or other monitors in need of initial training are urged to contact the State Office of Civil Defense so that training sessions can be arranged. Most of the monitoring instruments needed for the state teams are already purchased.

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

MADISON'S ATTIC ANGELS CREATE HEAVEN FOR INVALIDS

Madison, Sept. 1.—Something unique in the way of a nursing home was opened in Madison April 1 when the Attic Angel Nursing Home accepted its first patient.

This home is a fine old family dwelling, completely remodeled for its new purpose, and beautifully furnished and decorated. It offers the best in diet and nursing care. It is equipped with a call-light system similar to those in hospitals. And the minimum charge is $50 a week—less than is charged by any first-rate tourist resort.

Added to this is the remarkable degree of rehabilitation noted among its patients. One elderly gentleman had so little interest in life when he came that he would not even feed himself—much less bother to get up and dress. Now he may be seen any day of the week, reading in one of the sunny downstairs rooms or hunting for an opponent at cards.

This improved outlook on the part of its patients comes, it is believed, from the variety of contacts provided through the volunteer assistance of the Attic Angels themselves. This group of women has a definite volunteer schedule. Several of them are at the home each day, doing odd jobs, reading to patients, writing letters for them, taking them to drive, or just entertaining them. The patients come to know them and look forward to their visits, and life for them, for the most part, is far more varied and interesting than it was in their homes.

The Attic Angels had their beginning when, in 1889, a group of young women were scouring a family attic in search of clothes for a needy family, and the father of one of them gave them their name in fun. They took their name seriously, however, and became a full-fledged philanthropic organization which has given to Madison a number of its needed improvements. One of these was the Visiting Nurses Association which was started by the Attic Angels in 1908 and has now become a Red Feather service.

The nursing home was established as the result of a need expressed by the Visiting Nurses of a home for people who are in constant need of nursing care though not sick enough to require hospitalization. Some such people are bed-fast, and others are able to be up during the day.

This home is particularly designed to care for post-operative patients, for the aged and for those who are victims of disabling chronic diseases such as Parkinson's disease and multiple sclerosis. Long convalescences such as those following rheumatic fever are also spent at the home. All patients are under the care of their own physicians. Out-of-town patients are accepted.

The Attic Angel home is not prepared to accept all types of cases, however. No patients under the age of 16 can be accepted, and neither do they accept mental patients, maternity cases, alcoholics or patients with contagious diseases. Elderly people with a mild degree of senility are not classed as mental patients, and are accepted. The home is staffed and equipped to care for 20 patients.

Several of their patients have been at the home since the opening day, but short-term cases are

Court Holds Municipal Hospitals Liable for Negligence of Agents to Private Patients

Madison, Aug. 3.—The Supreme Court of the State of Wisconsin has handed down a decision of importance to those who own or operate hospitals.

In the case in question, Carlson vs Marinette County, a woman sued the Marinette hospital as the result of a burn suffered when a scalding-hot hot water bottle was placed in her bed. She was awarded damages in Circuit Court, and the hospital appealed to the Supreme Court where the decision was upheld.

The Supreme Court held that where a paying patient is concerned, a branch of municipal government such as a city or county, in owning or operating a hospital, is "acting as a proprietary hospital to the patient and is therefore liable for negligence on the part of its agents," just as privately owned hospitals are.

The opinion makes an exception to this in the case of paying patients hospitalized when "public health and safety are involved." This is thought to mean when a hospital is caring for patients suffering from some infectious disease such as polio, where the segregation of the patient is essential to the health of the community.

The Court also pointed out that a municipally owned and operated hospital, in caring for a patient on a non-profit basis, is acting in a governmental capacity and is therefore not responsible for employee negligence. Charity hospitals are, of course, exempt from suit.

It is the usual practice for all hospitals which are not strictly non-profit, tax-supported institutions, to carry public liability insurance written to cover negligence or malpractice on the part of hospital employees.

Copies of this court opinion have been distributed to all hospital administrators in Wisconsin by the State Medical Society. Copies also went to the society's councilors and officers, county society secretaries and members of the Committee on Public Policy.

Wisconsin Gains 990 Hospital Beds With More to Come

Washington, Aug. 21.—Two new projects have been approved for Hill–Burton hospital building grants. One of these is Memorial Hospital at Lancaster, which will be a new, 32-bed structure costing approximately $600,000. Of this, $270,000 has been supplied by the federal government and $330,000 has been raised locally.

The other new grant has been allowed for Lakeland Memorial Hospital, Woodruff. This hospital, already under construction, will cost $136,724, of which $38,419 is the federal share. It will be an 18-bed facility, new in the community, whereas the Lancaster hospital will replace an obsolete facility.

To date, a total of 990 hospital beds have been supplied in Wisconsin under the Hill–Burton act at a total cost of $15,715,275, of which $6,132,484 was federal money.

Twelve projects now under construction will supply 699 more beds at a cost of $12,853,204. Of this, $4,299,291 is federal funds and $8,553,913 locally raised.

Five hospitals approved but not yet under construction will add 131 beds more, at an estimated cost of $1,851,724, of which $810,-169 is federal money.

Thus the number of hospital beds has increased from 11,199 to 12,206 since the inception of the Hill–Burton Act, and this figure will be raised to 13,001 when all projects now approved have been completed. By then, the national treasury will have contributed $11,-192,444 while Wisconsin citizens will have reached into their own pockets for $30,316,160.

welcomed. Old people who live in the homes of sons and daughters have come to the home while their families are on vacation—and some of them have been reluctant to go back at the end of this time.

According to the director, Mrs. Doris Keslin, this is because, with the other patients and the volunteers as well as the nursing help, people have many more personal contacts and are far less lonely than they are in a family of busy younger people who can attend to their wants only occasionally.

Mrs. Keslin is a registered nurse who received her training at Milwaukee County School of Nursing and has been supervisor of a large surgical ward at Wisconsin General.

Her staff consists of another registered nurse, eight practical nurses, a cook and her assistants, a janitor and a senior medical student who sleeps at the home in order to be on hand for possible night emergencies. The mechanical and financial details of operating the home are handled by an operating committee of the Attic Angels group.

Physicians who may wish more details about the Attic Angel Nursing Home may write directly to the home at 102 East Gorham street, Madison.

University of Wisconsin Gets Research Grant

Madison, Aug. 1.—Dr. John W. Harman, a pathologist on the staff of the University Hospitals, has received a grant from the Muscular Dystrophy Association of America, Inc., for a special muscular dystrophy research project. The grant is slightly in excess of $18,000.

PROFESSIONAL BUSINESS SERVICE
227 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

A FORUM FEATURE

INVESTIGATE EUROPEAN GROUP

MARQUETTE STUDENTS HAVE STRONG INTEREST IN SAMA

By DAVID J. LaFOND

President, Marquette Chapter, Student American Medical Association

Marquette university medical students are continuing to take a strong interest in the Student American Medical Association, as was shown by our attendance at the last SAMA meeting held in Chicago in June. Our delegation was large enough to permit us to have an observer at every session and reference committee meeting.

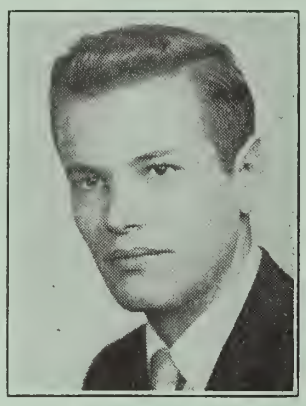
It was my privilege to attend this meeting as Marquette's official delegate. Robert Pavlic, who was delegate at the last annual meeting, served as alternate, and we deeply appreciate the financial support of the State Medical Society which made our attendance possible.

This was the third annual meeting of the SAMA, and the second held in less than a year, since the time of meeting has been changed from Christmas vacation to spring.

A new issue which was raised at this meeting had to do with the International Conference of Medical Students in Europe—whether we should send a representative to their meeting this summer. It was decided that we did not know enough about the group to warrant our attendance. A resolution was adopted that the executive committee investigate this organization as completely as possible and report on it to all chapters before our next convention.

The report of Russell Staudacher, executive secretary of SAMA, revealed that there are now 63 active chapters, and six or eight which are expected to join this year. He also reported that the SAMA Journal is to be enlarged and several new departments added. A newsletter is to go out from the office of the secretary each month. The group is not yet financially able to swing a student loan fund, but efforts are being turned in this direction.

The reference committee on internships recommended that the chapters encourage orientation on the problems of internship early in the career of medical students. It also recommended appointment of a three-man committee to investigate the offices of the national internship matching plan and prepare a report on it which is to be submitted to the SAMA Journal the following year. There seems to be some confusion in the minds of many students as to the advisability of this plan.



DAVID J. LaFOND

The reference committee on Selective Service came up with the following recommendations:

1. That a request be sent to the director of Selective Service that every effort be utilized to make the best use of medical manpower in the armed forces, that the possibility of the use of civilian contract physicians in the service be investigated, and that congress be petitioned to make provision for the care of service and service-dependent personnel;
2. That all new developments in the doctor draft law be thoroughly explained in the Washington Wire column of the SAMA Journal;
3. That the standing committee on Selective Service send questionnaires to the local chapters to gain opinions on the revised doctor draft;
4. That the standing committee investigate service hospitals assignments for interns and residents who are in the armed forces.

David J. LaFond, Junior student at Marquette University School of Medicine, was elected vice-president of the Student American Medical Association at the annual meeting held last June. His home is in Green Bay.

The reference committee on medical education passed a resolution that further investigations be made about preceptorship programs which seem to work out very well in several schools. It also resolved that local SAMA chapters should set up high school advisory committees and committees to furnish advice and information to premedical students, similar to the program at Marquette Medical School.

This resolution was submitted by Marquette, and received a fine reception. Robert Pavlic was asked to write an article about this system for fall publication in the SAMA Journal.

One panel that was of particular interest was on the subject of "General Practice as a Specialty." Speakers included Dr. W. B. Hildebrand, Menasha, president-elect of the American Academy of General Practice, and Dr. Robert Purtell, Milwaukee. Dr. Purtell spoke of the problems of the general practitioner in a large city and Dr. Hildebrand told of small town problems. Dr. John S. DeTar, Milan, Mich., completed the picture by talking on a rural general practice.

It has tentatively been decided that the next annual meeting will be held in early May since the June date of this year conflicted with examination schedules at a number of schools.

Less Than 1 Per Cent of U. S. Population Lives 25 Miles from Any M.D.

Chicago, Aug. 20.—Approximately one fifth of 1 per cent of the population of this country lives more than 25 miles away from a physician in active practice.

This percentage includes about 237,000 persons, most of whom live in the Rocky Mountain and Great Plains regions, according to a recent bulletin published by the Bureau of Medical Economic Research of the American Medical Association. Maps contained in the bulletin show doctors located nearly everywhere except in some sparsely settled sections of the West.

AMA HEAD CALLS VA HOSPITAL SYSTEM A CHAIN OF MEDICAL SUPER-MARKETS

Denver, Aug. 22.—"A chain of federally-operated medical supermarkets," detrimental to the health and economy of the entire nation is still in the making, according to Dr. Edward J. McCormick, Toledo, O., president of the American Medical Association.

Speaking before the Rocky Mountain Radiological Society's conference in Denver, Dr. McCormick called for a halt in the expansion of federal medical care for veterans with non-service-connected disabilities. He says they cannot be continued indefinitely without damaging the nation's economic structure.

Dr. McCormick stressed that the AMA does not seek to eliminate free medical care for veterans with disabilities or diseases which are service connected or aggravated. It also favors care in existing facilities for tuberculosis and psychiatric veteran patients because of the lack of local facilities to care for these conditions in many places.

Would Improve Quality

"The AMA seeks," said Dr. McCormick, "to improve the quality, availability and efficiency of such care by taking out of VA hospitals large numbers of patients whose disabilities would have developed even if they had not seen one single hour of military service."

Dr. McCormick explained that he did not believe everyone working for federal subsidation of medical care is purposely working against the interests of his countrymen.

"There are many zealots among them who sincerely believe in what they are doing," said Dr. McCormick. "Their greatest fault is that they are woefully ignorant of basic medical economics. And some, such as leaders of certain veterans' organizations, are unwittingly planting the seeds of socialization when they continue to foster the expansion of free medical care for veterans regardless of need and service connection.

"Some leaders of veterans' groups claim preferential status for all veterans. In a democratic nation we cannot have two types of citizenship. To serve one's country is a duty and an honor, and the only claim which any of us have as basic right is that principle for which we fought—individual freedom and dignity. We did not follow the colors to become wards of the government."

There are currently about 20,000,000 veterans in this country, and this number is increasing at the rate of approximately 1,000,000 annually.

PUBLIC RELATIONS TIP FOR SEPTEMBER

Psychologically, there is a jagged break in the ideal doctor-patient relationship when a patient with a minor ailment is dispatched with a prescription after one visit to the doctor. "How can the doctor tell whether the medicine helped me or not?" wonders the patient.

Many doctors solve this problem by handing such patients self-addressed postcards and asking them to report on their condition in a day or two. It is a friendly "let me hear from you" gesture. (From the American Medical Association bulletin, "PR Doctor.")

Conferee's Disagreement Delays VA Appropriation

Washington, Aug. 1.—A total of $555 million dollars for maintenance and operations of hospitals is being allowed to the Veterans Administration for the current fiscal year.

Congress also voted $20,573,100 for contract hospitalization, $24,248,200 for maintenance and operation of domiciliary facilities and $92,677,900 for out-patient care.

Final passage of the appropriation was held up while conferees strove to reach a decision on how much to allow for construction of three neuropsychiatric hospitals, in San Francisco, Topeka and Houston. The Senate pared the House figure from $48,867,000 to $2,500,000 and earmarked it for planning. The conferees agreed to add $15,000,000 so that construction could start.

Both houses agreed that VA should make a survey of its entire hospital construction program, including the sites it owns, and report back to Congress by next February.

Sincock Reappointed to Advisory Board

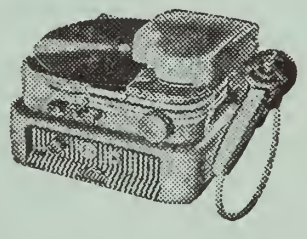
Madison, Aug. 12.—Reappointment of Dr. H. A. Sincock, Superior, to the Advisory Hospital Council of the State Board of Health has been announced by Wisconsin's chief health officer, Dr. C. N. Neupert. The appointment is for three years. He has served on this council since 1950.

Dr. Sincock is a former president of the Douglas County Medical Society and also of the Ashland–Bayfield–Iron County Medical Society. He is currently serving as chairman of the Division on Crippled Children of the State Medical Society's Commission on State Departments.

Dr. Sincock is also a fellow of the American Academy of Pediatrics and is president of the Northwestern Pediatric Society. He is a member of the State Board of Nursing, on which he has served since 1949.

DOCTORS!!

Make light work of writing work with AUDOGRAPH



● Here's the most compact, most versatile of all dictating machines — the 16-pound GRAY AUDOGRAPH. Simple to use — just pick up the "mike" and soundwrite memos, reports, letters. Nothing to adjust — and one flexible, "use-again" disc holds over an hour's dictation. *Really* portable — lets you dictate at home or office. Call today for a free demonstration.

JOHN NICHOLS, INC

541 NORTH BROADWAY
MILWAUKEE 2, WISCONSIN

See AUDOGRAPH at the Milwaukee Convention—Booth 27
Oct. 6, 7, 8

National Selective Service Advisory Group Thinks No More MD's to Be Called for Year

Washington, Sept. 2.—The National Advisory Committee to Selective Service, headed by Dr. Howard Rusk, has released information stating that "it is not expected that there will be additional calls for physicians placed against the Selective Service System by the President for the next twelve months."

The statement continues "As a result of Call No. 16 in August and the increased number of volunteers, there have been commissioned a sufficient number of physicians to meet the needs of the armed forces for the immediate future. Those who have been commissioned from either the voluntary list or the Selective Service Call will be brought to active duty from time to time until this reservoir is exhausted.

"There may be some calls on the Selective Service System for dentists, and there will be, of course, some dental reservists brought to active duty. There are some volunteers from the dental profession and no dental call is expected for several months.

"Public Law 84 specifically designates that the Committee give advise in regard to residents, teachers, and research workers. As you know, this is a lull year and it will be necessary to watch situations in communities, medical schools, hospitals, etc., so that when calls are re-established we will find only, as an unusual exception, any of those who are liable, in essential positions. In this connection it is necessary to establish, and keep up to date, rosters about which the Committee will write further at the time we distribute funds for the operation of the program this year."

COMMUNITY ENROLLMENT—

(Continued from page 525)

thusiastic endorsement was obtained for the program. A letter signed by Dr. W. H. Scherping, president of the medical society, was widely distributed, and similar letters were obtained from the hospitals.

This "trial run" which was undertaken with no previous experience to go on, and with little offered by other states in the way of advice, has provided valuable instruction for future campaigns.

Special Assistant to Mrs. Hobby Boston MD

Washington, Aug. 12.—Dr. Chester Keefer of Boston has been appointed by President Eisenhower to serve as the Special Assistant for Health and Medical Affairs to Mrs. Oveta Culp Hobby, Secretary of Health, Education and Welfare.

Dr. Keefer has been a professor of medicine at Boston University School of Medicine. He received his medical degree from Johns Hopkins in 1922. He has been physician-in-chief at Massachusetts Memorial Hospital since 1940.

Dr. Keefer is an expert on antibiotics, having supervised penicillin and streptomycin distribution for the U. S. and our allies during World War II. He was chairman of the National Research Council's committee on chemotherapeutics which advised on civil defense medical stockpiling. He is a fellow of the American College of Physicians, a member of the American Society of Clinical Investigation and has served on the American Medical Association's Council on Pharmacy and Chemistry.

As Special Assistant, Dr. Keefer will review all health and medical programs of the department as well as health and medical legislation, and will advise Mrs. Hobby on them.

Former Wisconsinite Is Head of New AMA Body

Chicago, Aug. 24.—Dr. Edward H. Leveroos, Oak Park, Ill., a native of Superior, has been appointed to the newly created position of director of the Division of Hospitals and Graduate Education of the AMA's Council on Medical Education and Hospitals.

Dr. Leveroos, who has been an associate secretary of the council, will be in direct charge of the council's program of approving hospitals for internship and residency training. He will represent the council in the program of the Joint Commission on the Accreditation of Hospitals.

Dr. Leveroos graduated from the Superior State Teachers College before going into medical training.

Proposed Extension of Social Security Would Cover MD's, Dentists

Washington, Aug. 7.—Extension of social security coverage to about ten and a half million professional and self-employed people would be accomplished by passage of H.R. 6812 recently introduced by Rep. Reed, R., N. Y.

Six and a half million persons who would be brought in by mandatory action would include physicians and interns, dentists, osteopaths, veterinarians, chiropractors, naturopaths, optometrists, Christian Science practitioners, funeral directors, professional engineers, lawyers, architects, accountants, and farmers.

Mandatory coverage would also be provided for farm workers and domestics earning $50 or more per calendar quarter from one employer.

About four million others who would be offered coverage on a voluntary basis would be ministers of the gospel and state and local government employees now enrolled in retirement systems. If this legislation passes, virtually the only persons not covered or eligible for coverage will be federal government workers and railroad employees.

The American Medical Association, the American Dental Association, the American Bar Association and a number of other professional organizations are on record as opposing this extension of social security. They favor legislation which would allow income tax deferment on a portion of earnings to be paid into restricted annuity plans.

"Today's Health" Placed In Beauty, Barber Shops By Evansville Doctors

Evansville, Ind., Aug. 8.—Evansville physicians are placing "Today's Health" in the beauty and barber shops of their city. This project was submitted by their Woman's Auxiliary who claimed, along with their husbands, that it was time "authentic and readable information on health and medical subjects should be made available to the public on a wide scale."

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Usefulness and Hazards in the Current and Popular Methods of Treatment in Cases of Acute Coronary Episodes

In such dramatic and potentially serious conditions as those of coronary thrombosis, the laity demands that something be done and done quickly. If the patient dies, it might be said that the physician didn't come quickly enough, but if the patient survives, he gets the credit no matter what the treatment may have been. Russek[1] has this to say, and I wish to quote him:

> ". . . 40% of all cases of acute myocardial infarction require little more than sedation for pain and medical guidance as to the duration and degree of restriction of activities. In these patients nature requires little assistance from the attending physician to bring about uneventful recovery. In the remaining complicated cases, however, careful evaluation of the signs and symptoms in the individual patient should dictate the specific measures most likely to influence favorably the natural course of the disease. The administration of drugs or procedures without clear indication should be avoided since there is no disease in which overtreatment or disregard of physiological concepts can prove more disastrous."

Actually, one can say much the same in regard to treatment of most other serious clinical conditions. Many drugs are potentially powerful and dangerous and can do much harm unless used with adequate discretion. Digitalis, our stand-by agent for the treatment of cardiac decompensation, can actually produce decompensation in a previously compensating heart. This statement should furnish an answer to the question regarding the so-called prophylactic use of digitalis in "anticipated" decompensation. Furthermore, the problem may well have its parallel in instances of a previously known coronary or cerebral vascular accident which was not followed by repetitions. Any experienced pathologist knows that in the aged, many scars of previously undiagnosed thromboses are found, and without histories of such accidents. On the other hand, sudden deaths occur in many instances without any previously recognized cardiovascular disease, but at autopsy these individuals are found to have had terminal coronary accidents. The question, then, may be raised as to whether or not, or when, everybody should begin to receive prophylactic anticoagulant medication! Heparin might be considered a hormone elaborated by the liver and therefore analogous to other endocrine secretions. Does there occur a hypo-heparinism, especially in instances of intravascular thromboses? This commentator does not know.

Some cardiologists initiate anticoagulant therapy beginning with heparin, since it acts very promptly. Then administration of Dicumarol, or some analogue, is begun. Because these substances act through effects on the liver, they are delayed in their actions on blood coagulability. Since heparin is known to interfere with coagulation of blood, the current idea or suggestion is that it relieves pain and dilates vessels through some process related to thrombus formation. The evidence is to the contrary, however, since Shore and associates[2] have demonstrated that heparin exerts a lytic action on lipoproteins, especially those of large molecular size. These investigations then suggest that the remarkable relief of pain occasionally observed after use of heparin in acute coronary cases may well be due to a lysis of the layered lipoproteins, thus removing them from the intimal lining of blood vessels. This, in turn, should permit free uptake of oxygen and removal of carbon dioxide from the smooth muscle layer and nerves immediately beneath these intimal cells. Engelberg[3] also maintains that the beneficial effects of heparin are not due to either vasodilatation or to the anticoagulant action. Furthermore, he points out that the maximal relief, through the use of heparin, occurs between

the 6- and the 24-hour period, long after the normal duration of the anticoagulant action of the intravenously injected drug.

Finally, attention should be called to the report of Flaxman[4] in respect to the liabilities of Dicumarol. He reported in 1951 the occurrence of 32 deaths from the orally ingested drug. Russek and Zohman[5] report the total of 122 known instances of death from hemorrhage following the use of heparin or Dicumarol in the course of treatment of myocardial infarction. These constitute new records for fatalities resulting from therapeutic application of drugs and should constitute an adequate warning of the dangers involved in the employment of these agents. —A. L. TATUM, M.D.

REFERENCES

1. Russek, H. I.: Therapeutic considerations and controversial issues in the modern management of acute myocardial infarction. Am. J. Med. Sci. 225: 589–598 (June) 1953.
2. Shore, B., Nichols, A. V., and Freeman, N. K.: Evidence for lipolytic action by human plasma obtained after intravenous administration of heparin, Proc. Soc. Exper. Biol. & Med. 83: 216–220 (June) 1953.
3. Engelberg, H.: Heparin therapy of severe coronary atherosclerosis, with observations of its effect on angina pectoris, the two-step electrocardiogram and the ballistocardiogram, Am. J. Med. Sci. 224: 487–495 (Nov.) 1952.
4. Flaxman, N.: Drug fatalities, J. A. M. A. 147: 377–379 (Sept. 29) 1951.
5. Russek, H. I., and Zohman, B. L.: Anticoagulant therapy in acute myocardial infarction. A survey of specialists' opinions concerning indications, results and dangers, Am. J. Med. Sci. 225: 8–13 (Jan.) 1953.

MARQUETTE–JACKSON CLINIC POSTGRADUATE PROGRAM
Saturday, October 3

On Saturday morning, October 3, the day of the Wisconsin–Marquette football game, the twenty-third annual postgraduate clinic presented by members of the faculty of the Marquette University School of Medicine and the staff of the Jackson Clinic will be held in the Tower of Health at the Methodist Hospital, Madison.

After the medical program presented by members of the faculty of Marquette and the staff of the Jackson Clinic, there will be a luncheon at the Loraine Hotel for the doctors and their wives.

Any physician who would like to attend the meeting and luncheon and who does not receive a reservation card may request one by writing Dr. Arnold S. Jackson, chairman.

Tickets for the Wisconsin–Marquette football game may be ordered from the Athletic Ticket Office of the University of Wisconsin.

The program is scheduled as follows:

Case Presentations — Members of the Jackson Clinic Staff

Recent Developments in the Treatment of Rheumatic Fever—Margaret Prouty, M. D.

Functional Uterine Bleeding—Lee B. Stevenson, M. D.

Illustrated Talk on Europe—Arnold S. Jackson, M. D.

Intermission

Present Concepts in the Treatment of Burns—Russell Kurten, M. D., Racine

Hypertension and Renal Failure — William L. Coffey, Jr., M. D., Milwaukee

Discussion—Francis D. Murphy, M. D., Milwaukee

The Discharging Nipple—James Garland, M. D., Milwaukee

Practical Concepts of the Rh Factor—Jack A. Klieger, M. D., Milwaukee

Luncheon at the Loraine Hotel for doctors and their wives

Football Game

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and
J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

REPORT OF A CASE *

History. This 61-year-old white female was admitted to Wisconsin General Hospital because of stupor, fever, and severe arthritis. For 5 to 6 years before admission she had had very severe rheumatoid arthritis involving the fingers, wrists, elbows, hips, knees, and ankles. Treatment of the arthritis had consisted of aspirin, codeine, and colchicine, and for 9 months before admission she had been receiving 100 mg. of cortisone daily. Two days before admission she had an onset of high fever, became drowsy and confused, and ate and drank very little. The condition had become progressively worse in spite of 600,000 units of crysticillin daily. Systemic review was essentially negative except for the arthritis and the presence of 2 or 3 loose stools the day before admission.

Physical Examination. Physical examination revealed a dehydrated, confused, lethargic white woman who appeared acutely ill. Her blood pressure was 124/80, pulse was 130, temperature was 101.4 F. axillary, and respirations were 36 and Kussmaul in character. There was acetone on the breath. Even the slightest motion caused acute joint pain, especially of the extremities. There was no nuchal rigidity. The pupils were round, regular, and miotic and reacted poorly to light and accommodation. The lungs were clear to percussion and auscultation. There was no definite cardiac enlargement. No thrills or abnormal pulses were noted. No murmurs were heard. The abdomen was distended but soft, and no organs or masses were felt. No tenderness was noted. There was marked inflammation of the ankles, knees, wrists, elbows, and fingers. There was exquisite tenderness over the thighs. There were typical rheumatoid deformities of the fingers and wrists with subcutaneous nodules over both forearms.

Laboratory Examination. Laboratory examination revealed a urinalysis with a specific gravity of 1.025, alkaline reaction, 0.02 per cent albumin, 3 plus glucose, and no acetone. There were 8 white cells per 10 high power fields and 1 red cell. There were 2 to 3 casts per low power field. The hemoglobin and red blood cell count were within normal limits. There were 10,350 white blood cells with 70 per cent neutrophils, 14 per cent stab cells, 9 per cent lymphocytes, and 7 per cent monocytes; 10 per cent nucleated red cells were seen. The blood sugar was 180 mg. per hundred cubic centimeters, and nonprotein nitrogen was 54 mg. per hundred cubic centimeters.

Course. The patient was started on 5 per cent glucose in water, crysticillin, aqueous penicillin, and streptomycin. On the following morning her carbon dioxide combining power was 20.5 milliequivalents, and chlorides were 88 milliequivalents. Tachycardia and tachypnea persisted. There was a trace of 1 plus glucosuria with no acetonuria in several specimens while the patient was getting the glucose infusion. Respirations became deep, rapid, and snorting in character, and the degree of coma increased. She expired 18 hours after admission.

Clinical Discussion

Dr. A. S. Evans: This protocol deals with a 61-year-old woman who had a history of arthritis of 5 to 6 years' duration. While under treatment with cortisone therapy an acute and severe illness suddenly developed, resulting in her death 3 days after its apparent onset despite antibiotic therapy with penicillin and streptomycin. This case has three primary aspects: the nature of the underlying chronic disease, the nature of the terminal episode, and the role of cortisone in modifying the final clinical picture and its possible role as a contributing factor to its pathogenesis.

The first problem is relatively simple. The protocol states clearly that the patient had a severe rheumatoid arthritis. This is supported by the presence of arthritic involvement in the fingers, wrists, elbows, hips, knees, and ankles. These lesions occurred in a middle-aged woman and existed over a

* From the University Hospitals and University of Wisconsin Medical School.

period of 5 to 6 years. They produced deformities in the fingers and wrists and were associated with subcutaneous nodules. The age of onset at 56 is, perhaps, a little later than is commonly seen in rheumatoid arthritis, but it does not prevent a diagnosis of a classical rheumatoid arthritis in this patient.

Her age of 61 years adds the possibility of an additional degenerative osteoarthritis, but this does not appear pertinent to the problem at hand. We are not told of the response of this arthritis to cortisone, but we may assume that it resulted in symptomatic relief, since it was continued for such a long period of time. We may also assume from the record on admission that the cortisone therapy did not reverse the deformities, since they were still present, as were the subcutaneous nodules. It is a well-known fact that cortisone therapy may successfully alleviate the clinical symptoms without affecting the anatomical changes. For this reason I accept the condition before the terminal event as a severe, uncomplicated rheumatoid arthritis.

The next problem is the nature of the terminal event and the possible ways in which it may have been altered or induced by the preceding cortisone therapy. The clinical picture in this terminal episode has three characteristics: the presence of a severe arthritis in nearly all the joints, the presence of a profound metabolic disturbance, and the presence of fever and disturbances in consciousness which may represent a severe and separate infection. The problem in the latter is whether this terminal episode is primarily metabolic or infectious or both.

It is important to know the effect of cortisone on the initial manifestations of this terminal episode, and it is important to know whether cortisone was stopped when the patient was admitted to the hospital. Cessation of cortisone therapy may result in a possible exacerbation of the arthritic manifestations. In this case the possibility exists that the prolonged cortisone therapy had led to an atrophy of the adrenals.

Dr. O. O. Meyer: No cortisone was administered while the patient was in the hospital.

Doctor Evans: Since no cortisone was administered, I am willing to accept the arthritic episodes during the final hospitalization as an acute exacerbation of the rheumatoid arthritis. Such relapses follow commonly after discontinuance of the therapy.

In the second place, we have a metabolic defect to consider. Many points in the protocol, such as dehydration, Kussmaul type of respiration, air hunger, lethargy, acetone smell on the breath, and a carbon dioxide-combining power of 20.5 milliequivalents combined with a low chloride level, indicate a severe acidosis. I cannot account for the presence of alkaline urine in such an apparent acidosis, nor can I explain the absence of acetone in the urine while it was present in the breath. However, I accept the presence of a severe acidosis on admission.

Parenthetically, one might ask whether an adrenal insufficiency was also present. The cessation of the cortisone therapy may contribute to such a picture, but the protocol gives no specific information in this regard except for mentioning a blood pressure of 120/80. This pressure may or may not have been normal for this particular individual. In addition, the low chloride level should be mentioned.

What is the cause of this acidosis? Acidosis of this degree is usually considered associated with uncontrolled diabetes or, perhaps, with renal disease. In addition to these two more common causes, one may add diarrhea, dehydration, and other factors.

We have little evidence for renal acidosis. The nonprotein nitrogen was 54, which is elevated but not striking, and no evidence of a chronic nephritis was present, no hypertension or previous history. Could this patient have had primary diabetic acidosis? The protocol mentions a blood sugar of 180 mg. per cent and a 3 plus positive glucose in the urine. Is it possible that cortisone had induced a diabetic state in this patient? It is well known that cortisone, as well as other adrenal steroids, has tendencies in this direction and that cases of diabetes due to these drugs are on record, some even of a severe character. A boy of 7 years was treated with cortisone and ACTH. Under this therapy severe diabetic acidosis developed, and the boy finally died. In normal people cortisone may induce glycosuria, and, in a group of hepatitis patients I had occasion to study, 100 per cent showed glycosuria under the influence of cortisone. However, I do not feel that diabetes was the primary factor in the acidosis in this case. We have, in addition, a probable infection, and we have the question of a lowered glycogen reserve due to starvation. For these reasons I believe

the acidosis was of complex origin, dependent on a combination of infection, enhanced by a low glycogen reserve, and on the metabolic effects of the cortisone therapy.

The infection is still an important problem. The protocol contributes little in this respect except for the presence of fever. This fever was one of the primary events, high fever with drowsiness and confusion. On admission, the axillary temperature of 101.4 F. represented a higher oral value. The blood showed a shift to the left with many stabs, the total white count was 10,300, and 10 per cent nucleated red cells were present, which might be attributed to the effect of the prolonged cortisone administration on the bone marrow.

Cortisone may mask the onset of an infection and may mask its symptoms. This has been shown in cases of pneumococcal pneumonia, peritonitis, typhoid, and other infectious diseases. Cortisone may also affect the primary inflammatory manifestations, such as the local inflammatory reaction, and it may retard the formation of granulation tissue. Cortisone also affects antibody formation and immunity. Profound effect on antibody formation by cortisone has been shown in animal experiments, but it has not been demonstrated in human beings. Treated cases of pneumonia developed antibodies at the expected time. However, some evidence in this direction may be found in the cases of hepatitis mentioned above, which relapsed promptly on cessation of treatment and which we attributed to a possibility of interference with the mechanism of immunity.

The third and probably the most important consideration in this case is the lowered resistance to infection or the enhancement of the severity of an infection associated with treatment with cortisone or ACTH. This has been well established in experimental animals for both bacterial and viral infections when these drugs were given either preceding the infection or during its course. A recent paper reports cortisone-treated mice dying from septicemia caused by invasion of intestinal bacteria. This shows that a normally present organism can become pathogenic for the host under the influence of this treatment. In human beings a few cases pointing in this same direction have been reported. Tuberculosis, as well as lobar pneumonia, has occurred during cortisone treatment. In the pneumonia case no clinical findings of the disease were present, showing that the diagnostic findings may be profoundly altered by cortisone treatment. Similar findings have been reported in a case of purulent pericarditis. The failure of the patient to respond to penicillin or streptomycin does not invalidate the concept that the disease has been caused by organisms normally susceptible to these drugs. Either the disturbance in the development of immunity or an overwhelming infection may explain the lack of response, even though the organism was susceptible. It is also probable that the treatment was started at a late point in the natural history of the infection. In an elderly patient pneumonia is statistically the most common infection and for that reason would be first choice in a diagnosis. It is also possible that, similar to the already mentioned experiments, a septicemia had developed by invasions of bacteria present in intestinal tract or kidney. The protocol gives little aid to establish a final diagnosis of the infection.

In summary I would suggest the following diagnosis: This is a case of severe rheumatoid arthritis which had responded clinically to cortisone therapy. In addition, there was a severe acidosis secondary to the infection but possibly related to a diabetogenic state induced by cortisone. Finally, a severe infection was present, the nature of which I cannot definitely surmise but which would most likely be pneumonia. The adrenal glands may show atrophy at autopsy.

Dr. H. J. van Baaren: Are there any x-rays available on this case? (None were available.) Are there any suggestions or questions before we present the autopsy findings?

Dr. John Rankin: The explanation of the acidosis with the presence of an alkaline urine is difficult, even when a sodium deficiency is also present. Therefore, I would like to know if the patient received salicylates before entering the hospital. The biochemical findings given in the protocol could be produced by large quantities of salicylates, which can also lead to a Kussmaul type of respiration.

Doctor Meyer: The record gives no information on this point; however, the protocol states that salicylates were given before admission. None were given during admission.

Dr. H. A. Hartmann: Did anyone consider amyloidosis in this case? We have seen pa-

tients in whom amyloidosis developed secondary to rheumatoid arthritis. Could this be suspected, taking the age of the patient into consideration?

Doctor van Baaren: I would like to ask Doctor Meyer if any suggestions of amyloidosis were present in the clinical findings or if it ever was considered in the diagnosis?

Doctor Meyer: No findings were present, and it was never considered.

Dr. H. A. Dickie: Did anybody consider a meningitis in this patient?

Doctor Meyer: To the best of my knowledge, no.

Doctor van Baaren: If no more questions are forthcoming, we will present the autopsy findings.

Necropsy Findings

(University Hospitals 52:309)

Doctor van Baaren: I would like to start by saying that when we began the postmortem we did not have the slightest idea where to look for the possible infection. We were as much in the dark as anybody else. However, when we opened the thoracic cavity a small amount of fibrinopurulent exudate was found on the anterior surface of the pericardium. On opening the pericardial cavity we found about 300 cc. of fibrinopurulent material. From this, Staphylococcus aureus was growing. In addition, Streptococcus faecalis and Bacillus coli were found, possibly as contaminants. Under the microscope the pericardium showed clearly a deposit of fibrin and a cellular exudate, establishing the diagnosis of fibrinopurulent pericarditis. The purulent exudate extended into the subepicardial fat tissue. High-power magnification enabled us to recognize polymorphonuclear leukocytes, but most of them were necrotic. No lesions of importance were found elsewhere in the heart; only a slight myocardial fibrosis was present. This finding of a purulent pericarditis explains the cause of death.

The lungs showed congestion and pulmonary edema, probably just as terminal findings. The spleen gave the typical picture of hyperemia as seen in the acute splenic tumor of infectious diseases.

These three findings were the essential ones: the pericarditis with the acute splenic tumor, the terminal congestion, and the edema of the lungs. There were few additional findings of interest. The liver showed a typical cavernous hemangioma which stood out as a dark red spot on the cut surface, as well as a slight chronic passive congestion. The adrenal cortex showed a possible influence of the cortisone therapy, hyalinization, and apparently a small area of necrosis in the cortex. The pituitary was 3 to 4 times its normal size and had many colloid cysts, and the basophilic cells appeared increased. Finally, arterial and arteriolar nephrosclerosis and a gastric ulcer were found.

Dr. D. E. Olson: What was the weight of the adrenals? Were they atrophic?

Doctor van Baaren: The adrenals had a normal weight, and no atrophy was found.

Doctor Evans: Did the pancreas show any evidence of islet changes?

Doctor van Baaren: Normal islets of Langerhans were present. We cannot, however, exclude changes on the basis of the hematoxylin eosin stain.

In the meeting of the American Association of Pathologists and Bacteriologists, one day was devoted to a symposium on the influence of chemotherapy and antibiotics on the microscopic and gross findings in infections. A paper given by Doctors Rebuck and Mellinger of the Henry Ford Hospital in Detroit dealt with the influence of cortisone on infections. They studied this by producing small skin wounds covered with a cover slip. The cells accumulating on this cover slip were studied at various intervals. They found that the appearance of phagocytic cells was diminished after cortisone treatment.

A paper given by Doctors Antopol and Saphra of the Beth Israel Hospital in New York stressed the appearance of so-called spontaneous infections after the administration of cortisone and ACTH. Statistical evidence was compared mainly on the basis of material gathered before 1946 and after that year. After 1946, chemotherapy had become an important factor.

Doctor Meyer: There were three possible explanations for the rapid respiratory rate of the patient. I emphasize the pericarditis, since the first sign of a developing pericarditis is an increased respiratory rate. Pericarditis usually involves the adjacent pleura. In addition, the pulmonary changes could affect the respiration. Finally, the severe acidosis influenced the type of respiration, leading to the Kussmaul type of breathing. In this case the rapid pulse and respira-

tion in relation to the temperature might have given a clue to the diagnosis, but the time of clinical observation was very short, and the patient was semistuporous.

Doctor Evans: I would like to re-emphasize the case reported by Armstrong in which a patient with mycosis fungoides treated with ACTH developed a purulent pericarditis due to Staphylococcus aureus. This is the second case of this type.

Doctor Meyer: This is not the first patient with arthritis who, under treatment with steroid hormones, developed a severe infection. Cortisone and ACTH have great value under certain circumstances, but a risk is present.

Doctor van Baaren: We have seen similar cases at postmortem, including two cases of severe purulent pleural inflammations without clinically recognized signs or symptoms.

CONTROL OF FIRE AND EXPLOSION HAZARDS IN HOSPITALS

A lecture and demonstration on "Fire and Explosion Hazards in Hospitals and Their Control" will be conducted by George J. Thomas, M. D., on Friday, Oct. 2, 1953, at 3:00 p. m. in the auditorium of the Marquette University School of Medicine, 561 North 15th Street, Milwaukee. This is a subject of vital interest, particularly to hospital administrators, operating room and delivery room supervisors, anesthetists, surgeons, obstetricians, and all other people concerned with the prevention of fires and explosions.

Doctor Thomas is professor of anesthesiology at the University of Pittsburgh School of Medicine. Since 1938 he has worked in close cooperation with the Explosives Division of the United States Bureau of Mines in Pittsburgh in research on the prevention of fires and explosions with flammable anesthetic agents.

This program is sponsored by the Wisconsin Society of Anesthesiologists with the cooperation of Marquette University School of Medicine. Anyone interested is cordially invited to attend this lecture and demonstration. For further information, please call Richard Foregger, M. D., BLuemound 8–5848, Milwaukee.

BOUGHT ANY NEW MEDICAL BOOKS LATELY?

Your older volumes would be gratefully received by the physicians, hospitals, and universities of Israel. Especially needed are books in the following categories, published since 1940:

All Medical Specialties
Anatomy
Aviation Medicine
Bacteriology
Biochemistry
Biology
Chemistry
Dentistry
Endocrinology
First Aid
General Practice
Gynecology and Obstetrics
Hospitals
Industrial Medicine
Internal Medicine
Medical Dictionaries
Mental Hygiene
Military and Naval Medicine
Nursing
Nutrition
Pathology
Personal Hygiene
Pharmacology
Physical Medicine
Physiology
Psychiatry
Psychology
Psychosomatic Medicine
Public Health
Surgery
Veterinary Medicine

If you can spare books on any of these subjects, please send them by prepaid parcel post to: BOOKS FOR ISRAEL, 115 King Street, New York 1, N. Y.

Note: Up to 70 pounds may be sent by parcel post, at 8¢ for the first pound and 4¢ for each additional pound, marked "Book Rate." Please give return address of individual or organization, so that your gift may be acknowledged. Funds for shipment from New York to Israel have been provided under Point IV, U. S. State Department, sponsors of this project.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 SEPTEMBER 1953 Number 9

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum—Janesville
J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS
THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Peshtigo
E. E. Kidder—Stevens Point

R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
A. H. Heidner—West Bend
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'—1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Fluorine in the Drinking Water

To fluoridate or not to fluoridate—that is the question. All over the country—east and west, north and south—the battle lines are drawn.

Some of the opponents to the use of fluorine in municipal water supplies are misinformed. Some of them raise the question of taste. Some engaged in the production of beverages of various kinds are frightened lest their competitors place them at a disadvantage because of the fluorine. Some are constitutionally or spiritually opposed to the revelations of scientific investigations.

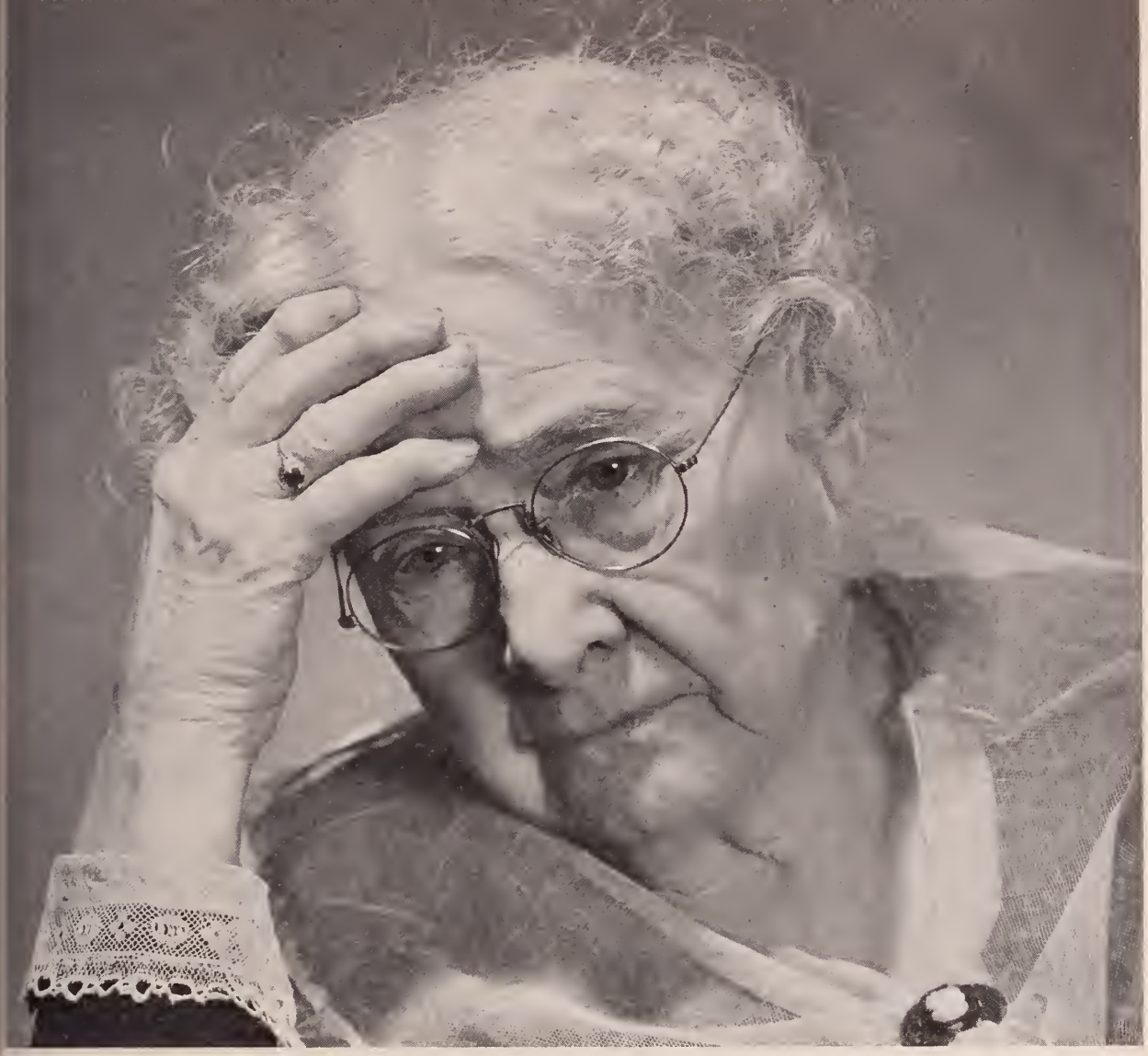
The facts of the situation on the subject are clear. They are the result of many years of epidemiologic, chemical, and animal experimental investigation. Attention to the effect of fluorine in water resulted from an early investigation by a Colorado Springs dentist, Frederick S. McKay. He noticed that many of his patients had stained or discolored teeth. Following these observations he made epidemiologic studies of areas over the United States where mottling of tooth enamel was reported to occur. He did not know the cause, but his epidemiologic investigations in the Middle West, Southwest, and Rocky Mountain areas convinced him that it was the result of some particular property of artesian well water.

In 1931 Petry and Churchill showed that in areas where mottling of the teeth occurred, the water contained fluorine. Subsequently, chemical examination of domestic water supplies has shown that wherever large amounts of fluorine (2 parts of fluorine per 1 million parts of water) occurred in the water supply there also occurred mottling of tooth enamel of the inhabitants who had grown up in such communities; where the water contained no fluorine no mottling occurred. This is proof that gross manifestations of dental fluorosis are associated only with fluorine content of domestic water supplies that approaches or exceeds 2 parts of fluorine in 1 million parts of water.

In the earlier studies the significance of fluorine levels lower than this was not recognized. It was not discovered until H. T. Dean and others after him had found that water supplies with lower fluorine content (around 1 p.p.m.) were significant in the control of dental caries.

Dean was the first to make a study of 34,000 children in South Dakota, and 48,000 in Wisconsin from eight cities—Green Bay, Sheboygan, Manitowoc, Two Rivers, Milwaukee, West Allis, Baraboo, and La Crosse. In the survey of these cities it was found that in the communities where the water contained no fluorine the DMF (decayed, missing,

(Continued on page 30)



The inevitable restrictions of advancing years, the reduced activity and a lowered intake of bulk-producing foods all contribute to the high incidence of constipation in older persons.

CONSTIPATION IN THE AGED

Constipation is almost a universal complaint of geriatric patients

Frequently, too, the protracted use of cathartics has left the colon in an atonic state and it is no longer capable of effecting a normal evacuation.

Metamucil has long been recommended for the treatment of constipation in the elderly. A highly refined vegetable product which is free from irritants, Metamucil effects a natural mechanical stimulus in the colon which helps the dysfunctioning muscles to regain and maintain their normal tone.

Metamucil may be safely prescribed for prolonged use without fear of dependence, intestinal irritations or allergic reactions.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

. . . . THE PRESIDENT'S PAGE . . . .

AS THIS is my final opportunity to bring you a message on this page, may I utilize it to say "thank you" for all that you, your committees, and your staff have done to make this what seems to be a good year for medicine in Wisconsin.

May I go back once again to the deliberations of the State Medical Society just a century ago, as printed in the Governor's messages of 1850–1855 in the library of the State Historical Society and review the stated purpose of this Society:

> To cultivate harmony and kind feelings amongst the members of our profession, to promote the advancement of the medical and collateral sciences to assist us in acquiring a knowledge of the same, and, in keeping pace with the progress of medical science, to help us appreciate the nature and magnitude of the mutual duties and responsibilities existing between the medical profession and the community, and to protect ourselves and society against the impositions of medical pretenders, we physicians and surgeons associate ourselves together.

It would seem that our purposes are just the same today as they were at that time.

We are still promoting the advancement of medical science, augmenting our own knowledge, and keeping pace with medical progress through our many postgraduate courses that reached such a high point of efficiency this year and will be brought to a fitting climax at the Annual Meeting.

We have endeavored in several ways to carry out our part of the mutual duties and responsibilities that exist between the medical profession and the communities.

The newly formed Commission on State Departments is made up of divisions on tuberculosis and chest diseases, maternal and child welfare, hearing and visual defects, rehabilitation, geriatrics, school health, public assistance, crippled children, and mental hygiene. These various divisions have been organized efficiently and are made up of men well versed in the various fields. They have studied the needs and inaugurated programs that should be helpful in all matters in which the state government and our profession should cooperate for the best interests of the public.

The Commission on Prepaid Plans has further developed Blue Shield in Wisconsin, increasing its scope and its coverage. A community enrollment program is being undertaken and the details of a catastrophic insurance plan are being worked out.

This has been a legislative year also, and it is refreshing to note that the legislators have adopted a revised Medical Practice Act that is in keeping with our times, together with considerable legislation affecting other phases of health. In each instance the final result has demonstrated that Wisconsin's law-making body has recognized that our stand is in the best interests of the public, not prompted by selfish aims. We are indebted to many outstanding legislators, many individual physicians, and to the hard-working Committee on Public Policy for the end result.

We in the medical profession have tried to maintain public confidence by policing ourselves through the delicate work of the Grievance Committee.

Any success that the State Medical Society has attained this year is due to your efforts individually, to those of your many committees, and to those of your staff. For this your retiring president is most grateful.

J. C. Griffith M.D.

535 North Dearborn Street, Chicago 10, Illinois

LCAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

SEPTEMBER 1953

$15,000 Fund Set Up for Research

Research in the basic medical sciences has been given a monetary boost. A grant of $15,000 from the William Volker Charities Fund of Burlingame, Calif., recently was accepted by the American Medical Association for research in this area of medicine. The AMA's Committee on Research, through its subcommittee on grants-in-aid, will be responsible for allocating the monies—in grants of from $500 to $1,000—to individual investigators conducting studies in the various basic sciences, such as anatomy, physiology, embryology. . . It has been felt that too much attention has been paid to clinical applications of disease treatment and not enough to action of the human body's normal cells and organs. Grants from the William Volker Fund should help to stimulate a more realistic balance between these two important phases of medicine.

Results of Survey of Physicians in Service

Results of the first six months of the continuing survey of physicians separated from active military service have been announced by the AMA's Council on National Emergency Medical Service. As of July 15, 1953, a total of 4,940 questionnaires had been sent out and approximately 3,270—or 66 per cent—had been returned. These questionnaires were set up to show (a) general information concerning the physician; (b) the extent of military training, branch of service, rank, etc.; (c) type of work performed while in service, efficiency of utilization, percentage of time spent on the care of military personnel, dependents, and other types of beneficiaries, staffing conditions for physicians and allied health personnel; and (d) comments and suggestions regarding the Armed Services and the part which organized medicine should play.

Several interesting points brought out in the survey: average total time spent in service by those responding—23 months; average tour of duty in the U.S.—15.6 months; average tour of foreign duty—7.4 months; average time spent in active service, exclusive of time spent in an Army or Navy specialized training program—15.7 months. The majority felt they were properly assigned and rotated. Willingness to remain in service for more than two years was indicated by 636 physicians. . . . One question, designed to obtain suggestions on how medical societies may be of greater service to doctors in service, was answered by only 50 per cent of the respondents. In addition to requests for more information the most frequently made suggestions were to have personal visits by civilian physicians to evaluate grievances, to invite physicians in service to civilian medical meetings, to assist in preventing evasion of military service, and to provide specialists for clinical conferences. With regard to over-all staffing conditions—576, or 23 per cent, indicated that they were overstaffed; 616, or 25 per cent, understaffed; and 1,304, or 52 per cent, adequately staffed. Comparatively few offered additional remarks—53 seemed dissatisfied with military service; 171 seemed satisfied with their tour of duty.

Copies of the survey report may be obtained from the Council on National Emergency Medical Service.

AMA Reports on Multiple Screening Services

Bringing together all available information on multiple screening techniques throughout the country was the object of a study recently completed by the AMA's Council on Medical Service. This technique involves the use of two or more simple laboratory tests, examinations or procedures, applied rapidly and on a mass basis, to determine *presumptive* evidence of unrecognized or incipient disease or defect. In the AMA's study, data has been compiled on some 25 multiple screening surveys ranging from small county and industrial plant projects to city-wide and state-wide programs. Data has also been gathered on some of the single case-finding programs such as mass tuberculosis surveys, and diabetes, cancer, and heart disease detection clinics. The report includes comments and conclusions by those directly connected with the surveys studied, plus other pertinent information such as the advantages, disadvantages, and ultimate goals of these programs. Copies of the full report will be distributed to all state medical societies. Additional copies will be available as long as the limited supply lasts. A complete bibliography on this subject may be obtained from the Council.

School Health Leaders to Gather for AMA Conference

School bells will toll again this fall . . . for the American Medical Association's fourth national Conference on Physicians and Schools. Sponsored biannually by the Bureau of Health Education, this year's Conference will be held Sept. 30, Oct. 1, and Oct. 2 at the Moraine Hotel, Highland Park, Ill. More than 200 representatives of state health departments, state education departments, and state medical societies have been invited to participate in discussions covering various topics of current importance in the school health field. Following the theme of "Health Services for School Children," the attendees will break up into a dozen different groups to tackle specific problems and develop suggested policies and practices. In addition, medical, public health, and educational leaders from 18 large cities will discuss big city problems in school health.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Britain's Medical Care

. . . The British plan is not insurance. Its users pay about 10 per cent of the cost. The other 90 per cent comes from the general treasury, which means primarily from the income and excise tax payers of the nation.

Because of this, there is little pressure from the users as such to keep down abuses which lead to high costs without commensurate benefits. Though it is admitted that there is considerable exploitation . . . by a minority, and that the quality of service can sometimes be questioned, few these days challenge either the plan or its cost.

. . . The cost, about $1.90 a month, is low compared with American costs for less comprehensive service. The British system seems to suit the British. Whether it would suit Americans is another matter.—MILWAUKEE JOURNAL, July 10, 1953.

The Advance of Ill Health

Dr. Ffrancon Roberts, a Welsh physician, has written of Great Britain's National Health Service:

"The preventive and curative triumphs of medicine are confined to acute diseases, many of which, in consequence, have been extinguished. In the case of degenerative disease, mainly confined to the aged, cure is by the very nature of the attack impossible. . . .

"Society is posed with the question: Shall the State spend millions on prolonging by a few weeks or months the lives of old people suffering from incurable disease while people whose sole ailment is advancing years are inadequately housed and cared for? We must also see life as a whole and consider the drain upon the young and active."—LANCASTER HERALD, July 29, 1953.

Professions Say No

President Eisenhower's proposal to bring doctors, lawyers and dentists under social security has already hit a snag, though specific reasons for the objections have not been stated.

An American Medical Association spokesman says his organization is "definitely and officially" opposed to including the doctors. An executive of the American Dental Association says his group has been opposed to it since 1949 when the subject was first broached. And a spokesman for the American Bar Association declares lawyers have opposed social security for their members for a long time.

But not all professional men feel that way about it. It has been the complaint of some attorneys that they have been barred from contributing to social security so as to be in line for its benefits. The pros and cons will probably be brought out when hearings are held on the Eisenhower proposal. —MARINETTE EAGLE-STAR, Aug. 6, 1953.

They're Qualified!

Grantsburg, still without a doctor, has through numerous avenues been seeking without finding. . . . Several facts become apparent, however, if Grantsburg will have and hold a physician.

Some individuals seem to possess the idea that a doctor must be an "old timer" in his field—that men out of school lack necessary qualifications. . .

Having studied and practiced through internship, a young medic is definitely ready to serve in the capacity for which he trained. Thus, in our estimation, there is certainly no reason to by-pass this source.

If and when regular medical assistance is secured for Grantsburg and its adjacent territory, you, the people, must decide not to use him merely as a first aid man, but place confidence for both minor and major needs. Otherwise the doctor may find a choicer practice elsewhere.—GRANTSBURG JOURNAL, Aug. 6, 1953.

Medical Expense Deductions

Under present law an individual may deduct from his income for federal tax purposes any medical expenses in excess of 5 per cent of his adjusted gross income. . . A person over 65 may deduct *all* his medical costs up to the maximum.

This law is intended, of course, to lighten the burden of catastrophic illness. It does not do so because it still puts a substantial tax burden on persons with high medical bills.

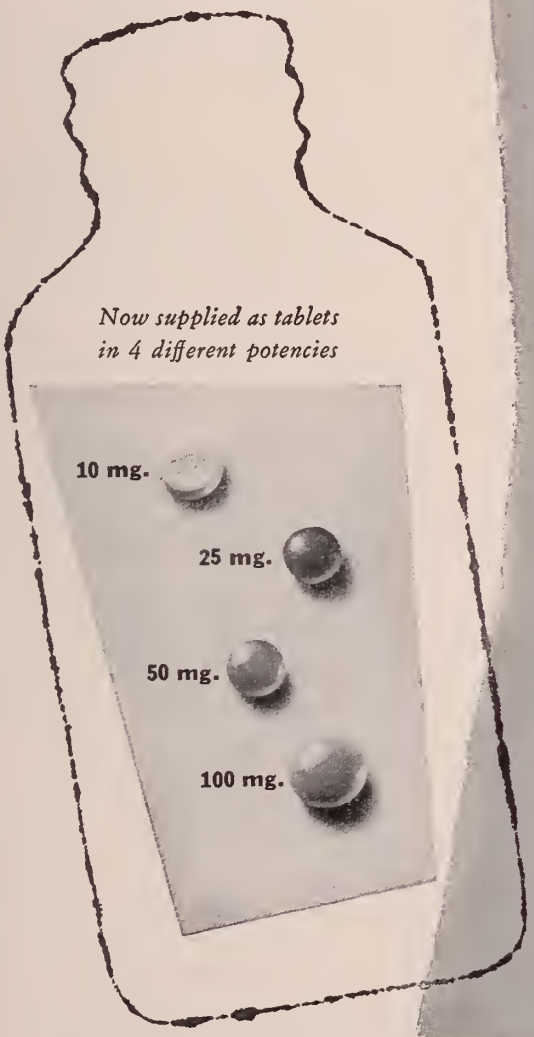
To remedy this it is proposed by some to permit the deduction of all such expenses, but only if they are more than 5 per cent of adjusted gross income.

The chief argument for this is that, if medical outlays are less than 5 per cent, there is no catastrophe. If they are more than 5 per cent, relief is called for and the relief should be without other limit than that imposed by a sensible definition of what constitutes medical care.—MILWAUKEE JOURNAL, June 14, 1953.

PRICE REDUCTION

20% PRICE REDUCTION* ON 50-MG. TABLET

20% ADDITIONAL SAVING* WITH NEW 100-MG. TABLET



Ciba

maintenance therapy with

Apresoline®

hydrochloride
(HYDRALAZINE HYDROCHLORIDE CIBA)

now costs less

Advantage may be taken of the economy and convenience of the new high potency 100-mg. tablet for maintenance therapy—provided the patient's particular dosage requirements have first been meticulously determined.

An antihypertensive agent of choice, Apresoline hydrochloride has oral efficacy, relative safety and freedom from toxicity. Even while lowering blood pressure gradually, as it does in the majority of patients, it increases renal blood flow and tends to reduce cerebral vascular tone so that cerebral circulation is not diminished. It constitutes a major advance in the treatment of hypertension.

Ciba Pharmaceutical Products, Inc.
Summit, New Jersey

*(druggist's cost)

2/19221A

COMMITTEE *Concentrates*

COMMISSION ON STATE DEPARTMENTS
JULY 17

MDs present: T. W. Tormey, Jr. (chairman), R. F. Purtell, R. G. Piaskoski, E. H. Pawsat, H. W. Carey, H. A. Sincock, E. D. Schwade, H. Kent Tenney.

The following reports were made by various Divisions:

Geriatrics . . . indicated need for medical guidance to county societies and other groups concerned with problems of the aged and recommended preparation of a guide for this purpose . . . recommended development of public forums, possibly a statewide institute, and urged leadership by the medical profession, to promote proper medical standards for care of the increasing aged population.

Public Assistance . . . recommended a joint study with the state agency comparing county fee schedules and policies, reviewed problems in connection with institutional care of public patients, and suggested county society cooperation with institutional medical directors in the formation of advisory committees to review matters of medical policy.

Rehabilitation . . . reviewed medical problems associated with rehabilitation work in Wisconsin, particularly as to revision of fee schedules . . . recommended appointment within the Commission of a special fee committee to study and make recommendations as to revised fee schedules applicable to all state agencies . . . accepted appointment as advisory committee to Rehabilitation Division of the Board of Vocational and Adult Education.

School Health . . . recommended periodic re-evaluation of school health practices through regional conferences in cooperation with county medical societies . . . was authorized to meet with school groups in formulation of policies for the conduct of competitive sports on elementary and junior high school levels . . . offered to serve in an advisory capacity to the W. I. A. A. in connection with medical regulations of that program.

Nervous and Mental Diseases . . . a subcommittee is evaluating problems relating to commitment laws and possible revision of the statutes at the 1955 session of the legislature . . . a subcommittee studying medical needs and understaffing of state institutions calls attention to the resident training program in psychiatry available at the U of W Medical School . . . another subcommittee is concerned with the lack of proper facilities for diagnosis and care of disturbed children, will make recommendations, and interest itself in the Diagnostic Center under construction in Madison.

COMMITTEE ON BLOOD BANKS
JULY 20

MDs present: W. D. Stovall (chairman), T. J. Greenwalt, C. N. Neupert, Paul Mason. Guests were Drs. E. H. Jorris, C. K. Kincaid, H. Kent Tenney, Merle O. Hamel, Milton Feig, N. G. Maxwell, Etheldred Schafer. Dr. Sam Gibson and Mr. Carl Belliston from American National Red Cross, Washington, and Dr. Raymond Barnes and Mr. Rollo McCall from regional Red Cross office in St. Louis were also present.

Doctor Feig gave a progress report on the current distribution of gamma globulin for poliomyelitis in Wisconsin. He read and explained Gamma Globulin Letter #7 from the Division on Civilian Health Requirements. He and Doctor Neupert then outlined the State Board of Health's recommendations in regard to procedure in the event that a mass immunization for poliomyelitis should become necessary anywhere in Wisconsin. Their most important point was that county medical societies should be fully responsible for any such project within their counties. The committee went on record as favoring these recommendations. It also approved Doctor Tenney's suggestion that all county societies should have on paper plans for possible arrangements for mass immunization and Doctor Kincaid's suggestion that polio committees be formed in all societies that do not have them.

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY MANSFIELD DIVISION

The committee also adopted a resolution for presentation to the Council that society presidents should appeal to their district councilors for help in the event of mass immunization.

The out-of-state Red Cross representatives explained certain rules governing blood bank advisory committees and certain requirements for blood donors.

GRIEVANCE COMMITTEE AUGUST 6

MDs present: R. E. Fitzgerald (chairman), E. W. Mason, F. A. Nause, C. E. Zellmer, H. W. Wirka, H. Kent Tenney.

In its second meeting on the subject of group malpractice insurance, the committee met with representatives of another insurance carrier. Recommendations will be made at a later date.

SUBCOMMITTEE ON COMMITMENT AUGUST 11

MDs present: Keith M. Keane (chairman), R. A. Jefferson, Michael Kasak, Owen C. Clark, J. F. Klepfer, J. T. Petersik, W. J. Urben, Henry Veit, A. A. Lorenz, Thorsten Smith, Leslie Osborn, Sara G. Geiger.

As a special meeting arranged with representatives of the Colonies, the Department of Public Welfare representatives of the Division on Mental Hygiene, and a committee of the County Judges Association, further study was directed to portions of the statutes relating to commitment procedures and special problems which confront courts and physicians in cases involving patients with marked mental illness. The discussion prompted the appointment of a smaller working committee of physicians, judges, and legal counsel of the Department of Public Welfare to refine suggestions offered to date and prepare specific recommendations which will be reviewed and submitted to the Commission on State Departments, and through it to the House of Delegates, for legislative interpretation in 1955.

STUDY COMMITTEE ON MATERNAL MORTALITY AUGUST 15

MDs present: T. A. Leonard (chairman), J. W. Harris, F. J. Hofmeister, Alice D. Watts, R. J. Sanderson, G. C. Hank, Amy Louise Hunter.

Special consideration given to procedures which would be followed if one of the cases before this special Study Committee happens to be referred to the Committee on Grievances from another source. Balance of meeting devoted to review of cases completed by interview, and a determination of reports to be submitted for final consideration and sent to attending physicians.

COMMITTEE ON NURSING EDUCATION AUGUST 15

MDs present: J. S. Devitt (chairman), G. S. Custer, G. B. Merline, R. C. Parkin, W. J. Tucker, J. H. Wishart.

As first meeting of this special committee, the major discussion was directed to the special problems confronting communities immediately concerned with nursing education programs, and projects which could be started to provide the committee with sufficient information to prepare a full report, with recommendations, to the Council on Medical Service in time for the 1954 meeting of the House of Delegates. This study will concern itself with the experience of present schools of nursing, interest in other communities in establishment of schools for practical nursing if present regulations could be modified, special problems retarding the expansion of training programs and the enrollment of nurses, and legislative changes, if any, that might be suggested to improve the situation which has resulted in a severe nursing shortage.

FLUORINE IN THE DRINKING WATER

(Continued from page 540)

or filled) rate for children under 12 years of age was three or four times greater than that in communities where the fluorine content was 1 p.p.m. or greater, and that in amounts of 1 to 1.5 p.p.m. gross mottling of enamel did not take place. Since these studies were made, many investigators throughout the country, including Bull, Nichols, and Frisch of Wisconsin, have made contributions confirming these results.

Now that the prophylactic value of optimal amounts of fluorine in communal water supplies has been established, the question is raised as to its toxicity for other body tissues and functions. In a long series of animal experimentations, Heyroth has shown that communal water supplies with a fluorine content optimal for dental health are well on the side of safety. He says, "The evidence as a whole is consistent in offering assurance that bringing the fluoride concentration in communal water supplies to that known to be optimal for dental health is a prophylactic public health procedure which has an ample margin of safety." It is apparent from all experimental results and epidemiologic studies that when fluorine is added to municipal water supplies in amounts necessary for the control of dental caries it does not cause noticeable mottling of tooth enamel, does not produce pathologic reactions in the body tissues or disturb physiologic functions, and does not impart a taste to water. —W. D. Stovall, M. D.

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

SENILE

For further information—
Director, Summit Hospital
Oconomowoc, Wisconsin

RADON SEEDS

FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

THE RADIUM EMANATION CORPORATION
GRAYBAR BLDG. Telephone MU 3-8636 NEW YORK, N. Y.

Society Proceedings

Ashland–Bayfield–Iron

M. J. REUTER, M. D.

Dr. Maurice J. Reuter, assistant clinical professor of dermatology at Marquette University School of Medicine, was guest speaker at the August 6 meeting of the Ashland-Bayfield-Iron County Medical Society, held at the Menard Hotel in Ashland. The title of the doctor's talk was "Benign and Malignant Moles."

During the business portion of the meeting, the society endorsed a schedule of newspaper ads and radio spot announcements calling attention to the "March of Medicine." The cost will be shared equally by the county society and the State Society.

Eleventh District

The Eleventh District Medical Society met at Pinecrest near Iron River on July 11. Forty members were present to hear the guest speaker, *Dr. J. C. Griffith*, Milwaukee, president of the State Society.

Wisconsin Academy of General Practice Manitowoc Chapter

Dr. Nelson A. Boner was elected president of the Manitowoc Chapter of the Wisconsin Academy of General Practice at the July 2 dinner meeting at the Hotel Manitowoc. Other officers elected were *Drs. Charles E. Wall*, vice-president; *Dr. Leon D. Sobush*, secretary-treasurer; Doctors Bonner and *E. C. Cary*, delegates to the state convention of the academy; and Doctors Wall and Sobush, alternates.

Officers of the chapter will arrange for a joint meeting with the Sheboygan, Fond du Lac, and Appleton chapters in September.

News Items and Personals

Sparta Honors Dr. Beebe

S. D. BEEBE, M. D.

An estimated 1,500 people—residents of Sparta and the surrounding area—gathered at the courthouse square in Sparta on Thursday evening, August 13, to pay tribute to the "dean of Monroe County physicians," *Dr. Spencer D. Beebe*. In 1954 Doctor Beebe will complete 50 years of service to the community.

Sponsored by the Sparta Kiwanis Club, of which Doctor Beebe is a veteran member, the celebration was much more simple than originally planned. Some months ago, when Doctor Beebe got wind of the elaborate plans being made by his fellow Kiwanians to honor him, he promptly vetoed the idea. It was only after considerable pressure that he agreed to be the center of any celebration at all—and he was firm in insisting that there should be no speech making. The Kiwanians didn't quite keep their promise, but despite a few speeches of tribute to the respected doctor, "Doctor Beebe Night" was a homey, simple affair, with entertainment by the Sparta Barber Shoppers (the doctor, a talented tenor and song leader, is a charter member of the group) and the Sparta City Band, and a community sing led by Doctor Beebe, with his daughter playing the accompaniment.

Doctor Beebe has practiced in Sparta since 1904. An 1896 graduate of Rush Medical College in Chicago, he completed his internship at Presbyterian Hospital there in 1898. After five years of general practice in Elroy, he settled in Sparta. A life member and past officer of the State Medical Society, he was honored by the Society as the "Wisconsin country practitioner of 1950."

Two Specialists to Practice with Marshfield Clinic

Dr. Russell F. Lewis, Jr., a member of the Marshfield Clinic who has been on leave of absence since January 1951, has resumed his practice at the clinic. For the past two-and-a-half years Doctor Lewis has been in residency at the Wisconsin General Hospital, where he specialized in obstetrics and gynecology.

A new member of the staff of the clinic is Dr. T. H. McDonell, who has been on the staff of Wisconsin General as a urologist for the past year.

Doctor McDonell is a graduate of the University of Wisconsin Medical School. He served with the Navy for two years and began his residency in urology at Milwaukee County General Hospital.

Hospital Elects Officers

A Genoa City physician, *Dr. Laird McNeel*, was elected chief of staff of the Burlington Memorial Hospital at a recent staff meeting. He replaces *Dr. Richard J. Dietz*, Waterford.

Other staff officers for 1953–1954 include *Dr. J. D. Van Liere*, vice chief of staff, and *Dr. L. W. Erickson*, secretary-treasurer. Both of the doctors are from Burlington.

Drs. Kores and Way Have New Associate

Dr. John A. Szweda, a graduate of the Stritch School of Medicine of Loyola University, Chicago, recently became associated with *Drs. A. B. Kores* and *Richard W. Way* in the practice of medicine and surgery in Beaver Dam. A former resident of Chicago, Doctor Szweda served his internship at Milwaukee County Hospital.

Physicians Report to Texas Base

During July and August several Wisconsin physicians reported to Fort Sam Houston, San Antonio, Texas, for two years of duty with the Army Medical Corps.

Dr. S. H. Ferguson, who reported on August 3, plans to resume his practice with *Dr. C. L. Weston* in New Lisbon after his tour of duty is completed.

Dr. R. E. Urbanek, a member of the Hoyer Clinic in Beaver Dam, also reported on August 3. During his absence his duties as secretary of the Dodge County Medical Society will be taken over by *Dr. R. F. Boock*.

Another member from Dodge County, *Dr. Thomas Lipscomb*, began his army service on July 1. He was formerly a resident at Milwaukee County Hospital.

The fourth physician to be called to San Antonio is *Dr. M. A. Cornwall* of Hudson. He has been associated with *Drs. M. G. Anderson, G. E. Bourget*, and *G. J. Hopkins* at the Hudson Clinic.

Mercer Has New Doctor

After three years with the Army Medical Corps in Germany, Dr. William Hiatt of Bluffin, Ind., has set up practice in Mercer, which has been without a doctor since *Dr. H. S. Ashe* was called into the Army last December. Doctor Hiatt is a 1950 graduate of the Indiana University School of Medicine.

Hess Clinic Takes New Member

At the completion of two years of service with the armed forces, Dr. John E. Thompson of Blanchardville has joined the staff of the Hess Clinic in Mauston. He started work on July 27.

A 1951 graduate of the University of Wisconsin Medical School, Doctor Thompson interned at Brooke

SHOREWOOD
HOSPITAL • SANITARIUM
2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

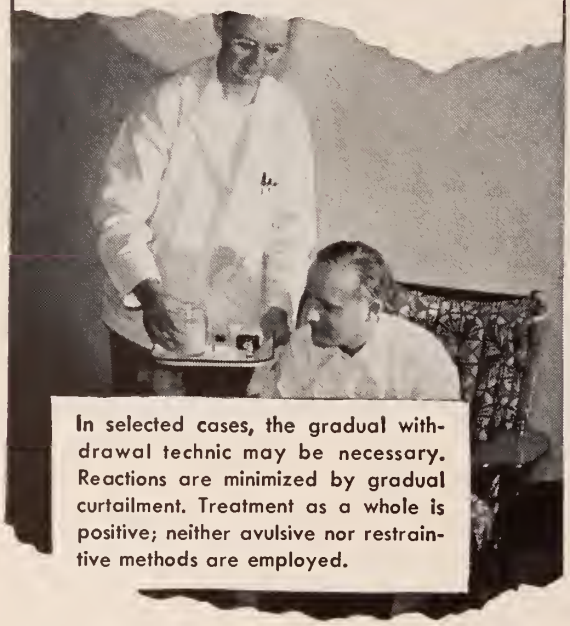
A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

Doctor..
You Have Patients with ALCOHOLISM



We can help you in caring for this type of patient—often described as the "Problem Drinker."

At The Keeley Institute we have the facilities and the specialized experience for outlining and carrying through a comprehensive, coordinated plan of therapy.

From the initial physical and laboratory investigations until the final evaluation prior to discharge, every step in the management of the patient is under the supervised control of full-time physicians.

As the referring physician, you are kept advised of the patient's progress. On dismissal the patient is referred back to you together with a complete report of pertinent findings.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Army Medical Center in San Antonio, Texas, and spent the past year at MacDill Air Force Hospital in Tampa, Fla., serving with the Air Force Medical Corps.

Doctor Scheurich Attends Reunion

Early in June, *Dr. L. G. Scheurich,* a practicing physician in Tomah for 43 years, attended the 50th reunion of his graduating class at Loyola College in Baltimore. As a 50-year graduate, he received a medal from the college.

Dr. Gage Returns to Kimberly

At the completion of his military service *Dr. R. S. Gage* has resumed his practice of medicine, surgery, and obstetrics in Kimberly. He will be associated with *Dr. D. W. Curtin.*

Brothers to Practice Together

Dr. Raymond W. Quandt of Jefferson has been joined in practice by his brother, Dr. Courtney E. Quandt, who has just completed a year's internship at St. Joseph's Hospital in Marshfield. Doctor Courtney graduated from Marquette University School of Medicine in 1952.

THIRD AND TWELFTH DISTRICTS NEWS

Three Physicians Join Monroe Clinic

Drs. Earl J. Sullivan, Henrik A. L. Hartmann, and Stanley Schilling have moved from Madison to Monroe to join the staff of the Monroe Clinic. Doctors Sullivan and Schilling are serving as resident physicians; Doctor Hartmann is pathologist for the Clinic and the St. Clare Hospital.

A 1949 graduate of Marquette University School of Medicine, Doctor Sullivan served his internship at St. Joseph's Hospital in Marshfield and a residency in neuropsychiatry at the Taunton (Mass.) State Hospital. He formerly worked with the maternal and child health service of the Milwaukee health department.

Doctor Hartmann, a native Norwegian, received his medical degree from the University of Oslo in 1949. After a period as a general practitioner in Norway, he decided to specialize in pathology and came to this country as a resident on the staff of Wisconsin General Hospital and the University of Wisconsin Medical School.

A 1952 graduate of the University of Vermont College of Medicine, Doctor Schilling completed a year's internship at Wisconsin General Hospital. before moving to Monroe.

Monticello Has New Doctors

On their discharge from the Navy early in July, *Drs. Charles O. Miller* and *Paul M. Lucas* of Milwaukee have set up practice together in Monticello

in the offices formerly occupied by *Dr. Charles Benkendorf,* who expects to serve for two years with the Navy.

Both of the new Monticello physicians are graduates of Marquette University School of Medicine and served as interns at the National Navy Medical Center in Bethesda, Md.

Dr. Hobbins Called into Service

Dr. William S. Hobbins of Madison reported on August 8 to Fort Sam Houston, San Antonio, Texas, for a 24 months' tour of duty with the armed forces. For the past two years he has been associated in practice with *Drs. R. T. Cooksey, I. R. Sisk, J. B. Wear,* and *C. S. Harper,* and served as attending surgeon at Madison General Hospital.

Doctor Hobbins took his medical training at Northwestern University Medical School and his surgical training at Chicago's Cook County Hospital. He is a diplomate of the American Board of Surgery, a junior member of the American College of Surgeons, and a junior member of the International College of Surgeons.

Dr. Hummer Takes Public Health Post

Dr. Francis L. Hummer, Madison physician, has been elected chairman of the Dane County Public Health Council, which serves also as the health panel of the Community Welfare Council. Doctor Hummer is the first practicing physician to hold the job.

A graduate of George Washington University School of Medicine, Doctor Hummer took further training at the University of Minnesota and John Hopkins University School of Medicine. He has been practicing in Madison since 1947.

Polio Workshop Held

Gamma globulin and its uses was the topic of the second in the series of parent workshops sponsored by the Green County Chapter of the National Foundation for Infantile Paralysis. Held on August 18 in Brodhead, the workshop was conducted by *Dr. W. D. Stovall* of Madison, director of the State Laboratory of Hygiene; *Dr. N. E. Bear,* medical adviser for the county chapter; and *Dr. Frank C. Stiles,* a member of the county advisory committee. A question-and-answer period followed the discussion.

In mid-August *Dr. John M. Irvin,* another member of the medical advisory committee of the chapter, spent a week in Columbus, Ohio, studying and observing the work of Dr. Warren Wheeler, national authority on the care of acute poliomyelitis.

Green

At the annual dinner meeting of the Green County Medical Society, held on July 28 at the Monroe

17–Ketosteroid
Determinations
Quantitative Gonadotrophin
Assays
Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES
5001 West Belt Line Highway
MADISON 5, WISCONSIN

"Orthopedic Appliances"
of every description
have been our specialty for 32 years.
Trained Mechanics and Fitters only
Trusses, Elastic Stockings, Abdominal Belts.
THE ORTHOPEDIC APPLIANCE CO., Inc.
123 East Wells St.
Tel. Daly 3021 Milwaukee, Wis.

BARR X-RAY CO.
Exclusive Wisconsin Distributors
for
F. MATTERN MFG. CO.
Quality X-Ray Equipment
1924 W. Clyboum St. Milwaukee 3, Wisconsin

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2-1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6-5303

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

Country Club, *Dr. Nathan E. Bear* was elected to succeed the retiring president, *Dr. David D. Ruehlman.*

Re-elected as vice president was *Dr. John A. Schindler. Dr. Dwain E. Mings* was elected secretary-treasurer to replace *Dr. Leslie G. Kindschi,* who was not a candidate for re-election. All the above-named physicians are from Monroe.

Green County member of the house of delegates of the State Medical Society will be *Dr. William D. Stovall, Jr.,* who succeeds *Dr. Melvin W. Stuessy.* Both doctors are from Brodhead.

New doctors admitted to the society at this meeting include *Drs. Earl J. Sullivan, Paul M. Lucas, Charles O. Miller, Donald W. Springer,* and *Henrik A. L. Hartmann.*

Dr. R. T. McCarty Wins Award

R. T. McCARTY

Dr. Robert T. Mc Carty, assistant professor of surgery at Marquette University School of Medicine, recently won the annual award of the Piedmont Proctologic Society for the best research paper in the field of proctology. The doctor presented his paper on cancer research in proctology at the national convention of the American Proctologic Society held in Boston.

A graduate of Marquette, Doctor McCarty practiced medicine in Appleton before entering service during World War II.

Dr. J. A. Larkey Returns to Milwaukee

Dr. Jay A. Larkey, who has been serving with the Navy, was recently released from active duty and has returned to his home in Milwaukee. Doctor Larkey is a graduate of Marquette and served a residency at Mt. Sinai.

SOCIETY RECORDS

New Members

J. L. Buhl, Route 1, Box 23, Hales Corners.
M. G. Apell, 46 Washington Boulevard, Oshkosh.
D. J. Ryan, 117 North Commercial, Neenah.
Reuben Beezy, 2754 North 49th Street, Milwaukee.
J. J. Frederick, 4449 South Packard Avenue, Cudahy.
N. M. Hilrich, 2750 North 44th Street, Milwaukee.
P. P. Wisniewski, 1117 West Mitchell Street, Milwaukee.
R. S. Gray, Evansville.
R. B. Anderson, 1922 University Avenue, Madison.
J. A. Beyer, 1922 University Avenue, Madison.
G. A. Bacon, 423 Main Street, Racine.

Changes in Address

D. E. Matthiesen,* Memphis, Tennessee, to Apartment 114B, Magnolia Springs Apartments, Green Cove Springs, Florida.

E. G. Clahassey, Madison, to 420 Medical Arts Building, Grand Rapids, Michigan.

W. G. Gillies, Hazel Green, to Wild Rose.

L. E. Plank, Wood, to Lovelace Clinic, Albuquerque, New Mexico.

H. N. Heinz, Kohler, to 1729 North Sixth Street, Sheboygan.

J. C. Bennett, Burlington, to Department of Radiology, University of California Hospital, San Francisco 22, California.

R. L. Hartzell,* Grantsburg, to Apartment 7, 223 Emporia, San Antonio, Texas.

L. E. Haentzschel, Appleton, to Box 151, Taunton, Massachusetts.

Clarence Samuelson,* Hartland, to 3310 Medical Group, Scott Air Force Base, Illinois.

G. G. Shields, Abbotsford, to Wisconsin State Board of Health, P. O. Box 270, Wisconsin Rapids.

B. J. Longley,* San Antonio, Texas, to 2128–1 U. S. Army Hospital, Fort Knox, Kentucky.

J. A. Schelble,* Hartland, to AO2260584, Third Hospital Group, APO 240, New York, New York.

N. P. Anderson, Crystal River, Florida, to 2027 Cass Street, La Crosse.

M. Q. Howard, Pocatello, Idaho, to %E. L. Howard, 6514 50th N. E., Seattle, Washington.

D. W. Kersting, Bethesda, Maryland, to 5021 Blackstone Avenue, Chicago, Illinois.

S. A. Korducki, Cleveland, Ohio, to 2719 South 15th Street, Milwaukee.

Joseph J. Mueller, Milwaukee, to 2331 North 65th Street, Wauwatosa.

Elaine K. Pedersen, Milwaukee, to 305 South 39th Street, Philadelphia 4, Pennsylvania.

E. K. Rath, Milwaukee, to South Shore, Eagle Spring Lake, Route 1, Mukwonago.

T. L. Buhl,* Los Angeles, to 107 New York Street, Travis Air Force Base, California.

Ervin Teplin,* Washington, D. C., to 4828 North Fourth Street, Milwaukee.

J. J. Coheen,* Milwaukee, to Madigan Army Hospital, Fort Lewis, Washington.

R. S. Gage, Langley Field, Virginia, to 314 Kimberly Avenue, Kimberly.

Ann Cinelis, Black River Falls, to Independence.

Alfred Wallner, Bakersfield, California, to Wilma Building, Missoula, Montana.

G. S. Riegel, St. Paul, Minnesota, to 935 Cheyenne Road, Colorado Springs, Colorado.

W. G. Dixon, Iowa City, Iowa, to Timberlane Sanatorium, Box 1769, Dallas, Texas.

K. P. Grubb,* Chicago, Illinois, to 1001 Elmwood, Evanston, Illinois.

R. F. Lewis, Jr., Madison, to Marshfield Clinic, Marshfield.

---

* Military Service.

Wide Medical Interest in New Knox Gelatine "Eat and Reduce" Plan

Developed and supervised by competent clinical authority, the new Knox "Eat and Reduce" Plan is intended especially for your overweight patients in otherwise normal health.

The plan has been tested on overweight patients with fine results. In addition, many physicians (and their families) have written us about their gratifying personal results with this plan.

The Knox "Eat and Reduce" Plan is a simple, sensible regimen that places no burden of exercise or hunger on the patient. Quite the contrary, it permits three tempting, solid meals daily, plus between-meal feedings. The menus have been carefully selected so as to provide an abundance of vitamins, minerals and protein. Many of the dishes utilize Knox Gelatine, which is, of course, all protein and no sugar — thus being an effective aid in weight reduction.

AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES.

Knox Gelatine U.S.P.
ALL PROTEIN NO SUGAR

USE THIS COUPON! ***Write today!***
Knox Gelatine, Johnstown, New York Dept. W S

Please send me FREE copies of the "Eat and Reduce" Plan, and Diets.

Name.....M.D.

Address.....

City.....Zone.....State.....

E. O. Niver, Eau Claire, to 1157 Sylvring Road, Cleveland Heights 21, Ohio.

P. R. Savino,* Milwaukee, to 3415th Medical Group, Lowry Air Force Base, Denver, Colorado.

Chalmer Davee, River Falls, to Edgewater Park, Mississippi.

D. J. Albrecht,* Milwaukee, to 6510th Medical Group, AROC, Edwards Air Force Base, California.

*Military Service.

MARRIAGES

Dr. John B. Toussaint to Miss Carol Towers, Madison, August 15.

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

DEATHS

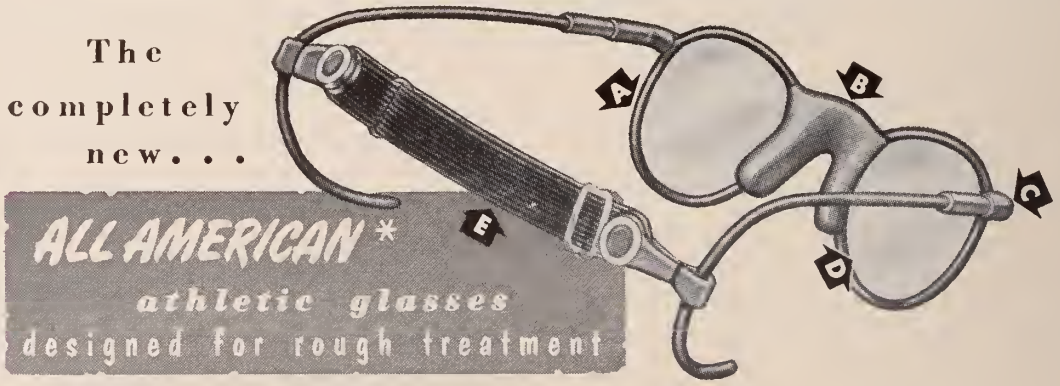
I. F. THOMPSON, M. D.

Dr. Ira F. Thompson, retired public health administrator, died on July 5 in a Beloit hospital. Born on October 1, 1877, he was 75 at the time of his death.

A native of Lawrence, Illinois, Doctor Thompson received his medical education at Bennett College of Eclectic Medicine and Surgery, graduating in 1900. After four years of general practice in Beloit and ten years in Reedsburg, he took graduate work in public health at the University of Wisconsin and received a master's degree in 1916.

For several years he worked with the State Board of Health, serving as deputy state health officer from 1916 to 1919, as organizer and director of the bureau of venereal diseases from 1919 to 1922, and as deputy and later acting health commissioner of the Milwaukee health department from 1922 to 1925. Leaving Milwaukee, Doctor Thompson worked for seven years with the Milbank Health

The completely new . . .



A. EXTRA STURDY ALL-METAL FRAME
B. "CUSHION FIT" SHOCK ABSORBENT RUBBER NOSE PIECE
C. ENDS COVERED TO PROTECT OTHER PLAYERS
D. SAFETY PRESCRIPTION LENSES WITH HIGH BASE CURVE
E. EXPANSIBLE, ADJUSTABLE "GLASS GARD"* HEADBAND

- One Price for All Prescriptions up to and Including 7 Diopters—Case Included
- Order Complete Sample Available at Nominal Cost or Write for Further Information

*Pat. Pend.

Since 1913 Benson OPTICAL COMPANY

EXECUTIVE OFFICES • MINNEAPOLIS, MINNESOTA

Complete Laboratories Serving Wisconsin: Beloit, Eau Claire, La Crosse, Stevens Point, Superior, Wausau, and Duluth, Minn.

Foundation as assistant to the health commissioner in Syracuse, New York. On his return to Wisconsin in 1932, he served as Racine health commissioner until 1945, when he retired and moved back to Beloit.

A member of the Wisconsin Anti-Tuberculosis Association, Doctor Thompson was elected to its board of directors in 1937, served as its president from 1945 to 1948, and was a member of the senior council of the organization at the time of his death. He had also served as vice-president and president of the State Board of Health. Until his retirement, he was a member of the American Public Health Association and had served on a number of its committees.

Doctor Thompson held membership in the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a member of the Fifty Year Club of the State Society.

He is survived by a daughter, Louise, Beloit; a son, Albert, Trumansburg, New York; and a sister, Mrs. O. R. Foster, Beloit.

Dr. Erwin E. Peters, Monroe physician, died on July 6 at the age of 42. He was born in New York City on December 19, 1910.

A 1936 graduate of Cornell University Medical College, Doctor Peters served as an intern and assistant resident at New York City Hospital from 1936 to 1939. After two years on the faculty of Johns Hopkins University School of Medicine, he entered the Navy, serving at Brooklyn Naval Hospital, in Panama, at the Great Lakes Naval Station, and in New Guinea and Australia. On his discharge in 1946 he was a commander.

After brief private practice in Forest Hills, New York, he went to Chicago as medical director of the Chicago Intensive Treatment Center. During his stay in Chicago he was also a member of the faculty of Northwestern University Medical School.

On October 1, 1948, Doctor Peters joined the staff of the Monroe Clinic as a specialist in internal medicine. Well-known for his work with skin disorders, neurology, and diagnosis, Doctor Peters took on heavy outside duties last year as medical adviser for the Green County Chapter of the National Foundation for Infantile Paralysis. Combined with his duties at the Clinic, this position kept him working tirelessly during last year's polio season.

Doctor Peters was a member of the American College of Physicians, the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a diplomate of the American Board of Internal Medicine.

Survivors include his widow, the former Ann Harris of Chicago; and two young children, Erwin H., 10, and Joan Carol, 4.

Dr. George H. Schlenker, retired Amherst physician, died on July 8 after an illness of three months. Born on February 28, 1881, he was 72 at the time of his death.

A native of Jackson, Michigan, Doctor Schlenker graduated from Loyola University School of Medicine in 1910 and returned to Jackson to serve as intern and later staff member at the city hospital there. On his discharge from the Army after World War I, Doctor Schlenker moved to Menomonie, where he was associated for a time with the Butler Clinic. In 1927, after practicing in Athens and

In Vegetable Gum Sensitivity

When patients are sensitive to vegetable gums (karayatragacanth, etc.) you can safely suggest AR-EX Wave Set. Uses quince seed extract as the mucilaginous agent. Does not dry powder or flake off hair. Available either Scented or Unscented.

In 6 oz. bottles at pharmacies

AR-EX WAVE SET

AR-EX COSMETICS, INC. 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

AR-EX
HYPO-ALLERGENIC
Cosmetics
CLINICALLY TESTED
FOR ALLERGIC PATIENTS

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
(The Pioneer Post-Graduate Medical Institution in America, Organized 1881)

SURGERY AND ALLIED SUBJECTS

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

EYE, EAR, NOSE AND THROAT

A combined full time course covering an academic year (9 months) It consists of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver); clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients preoperatively and follow-up post operatively in the wards and clinics; attendance at departmental and general conferences. Also refresher courses (3 months).

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

Wittenberg, he settled in Amherst. Ten years later he entered state service and became a member of the medical staffs at the G. A. R. Home in King and at the Southern Colony in Union Grove. He retired from active practice about five years ago.

Doctor Schlenker's first wife died in 1926. He is survived by his second wife, the former Alma Waller of Nelsonville; and two children by his first marriage, Mrs. Robert Oberhofer of Milwaukee and Dr. George M. Schlenker of Albuquerque, New Mexico.

Dr. Ernest A. Petzke, retired Hixton general practitioner, died at his home on July 8 after an illness of six months. He was 81.

The doctor's family came to this country from Germany in 1843 when Wisconsin was still a territory. They located between Milwaukee and Racine, where Doctor Petzke was born on May 14, 1872. After finishing high school, he attended the Northwestern University Medical School, graduating in 1896, a member of the first four year medical class. He practiced a short time in Racine and in Madison before moving to Hixton, where he practiced without interruption until his retirement in 1947.

Active in community affairs, Doctor Petzke served as clerk of the Hixton school board for 21 years, helped to organize Hixton's PTA, was a past member of the Jackson County Board of Supervisors, and organized and served as the first president of the Commercial Club. During World War II he was a member of the Selective Service Board for Jackson County.

Doctor Petzke was a founder and past-president of the Trempealeau–Jackson–Buffalo County Medical Society and was granted life membership in the State Medical Society of Wisconsin in 1949. He also was a Fellow of the American Medical Association and a member of the American Association for the Advancement of Science.

His wife, the former May F. Singleton, survives him.

RADIUM and RADIUM D+E

(Including Radium Applicators)

FOR ALL MEDICAL PURPOSES

Est. 1919

Quincy X-Ray and Radium Laboratories

(Owned and Directed by a Physician–Radiologist)

HAROLD SWANBERG, B. S., M. D., Director

W. C. U. Building Quincy, Illinois

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building **Omaha 2, Nebraska**

$200,000.00 deposited with State of Nebraska for protection of our members

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Medicine. Edited by Hugh H. Garland, T.D., M.D., F.R.C.P., and William Phillips, M.D., B.Sc., F.R.C.P. St. Martin's Press, New York, 1953.

Something new in medical texts!

This two-volume textbook on medicine embodies many innovations in its departures from the conventional presentation of the subject for students and physicians. In the foreword, Professor F. A. E. Crew found the keynote as follows: "If, in addition, such a book skillfully attempts to stimulate thought and inquiry and encourages the cultivation of a philosophical attitude, then indeed those who undertake the task must command our gratitude and admiration." Deploring the neglect of the humanistic sciences, he further emphasizes the social function of medicine: "Knowledge and skill can never be enough; coupled with them must be sympathy, compassion, and indeed a love of mankind and an ardent desire to aid humanity to achieve its terrestrial destiny. Ethics and morals must be solid threads woven into the texture of medicine."

On this high plane, this new textbook launches into a discussion of such topics as "The Evolution of Modern Medicine," "The Assessment and Promotion of Physical Health," "The Assessment and Promotion of Mental Health," "The Natural History of Disease," "Social Aspects of the Etiology of Disease," "The Genetic Factors in Disease," "The Patient as a Person," "Nutrition and Disease," "Infection and Immunity," and "Neoplasms." The philosophic handling of these subjects is as refreshing as it is new to the modern text. To capture one of the phrases in the characterization of Sydenham, one might say that they "ventilated not only by throwing open the windows but by bringing . . . a freshness of mind that was unprejudiced but characteristically English." From the historical as well as the philosophical standpoint, these sections are singularly broad in their concept and sound in their execution. Throughout their diversified considerations runs the thread of human interest and protection of the individual patient who is suffering from a "disharmony" as the host of some noxious agent or other disturbing force. The iatrogenic influences are frontally met.

Almost is one persuaded to subscribe to the light touch: "Civilized mankind would be a good deal healthier if stethoscopes could be fitted with a device to prevent the systolic murmur being heard." The section on mental health is exceptionally well handled and the reviewer would agree that "the record of medicine in this field has been neither very courageous nor very scientific." The evolution of the appreciation of mental health must begin with infancy. Humane instincts and extended experience in interpersonal relationships would confirm the essayist's advice that "in the first year or two of life there must be some place every day for a real practice of intimate affection between her (the mother) and the child—half an hour of loving!" The further factors in the maintenance and failure of mental health receive appropriate consideration. "The Natural History of Disease" is a classical contribution. A minor error has crept into the dating of the modern knowledge of status anginosus, which should be dated to 1910 in the work of Obratzow and Strachesko. The happy resolution of the development of clinical sense in terms of the "systematic education of the association tracts" strikes a sympathetic chord.

Naturally, the subject of social medicine receives due attention in this new text. Great Britain is in the throes of a conscientious effort to render the National Health Service Act of 1946 effective. The section on the "Social Aspects of the Etiology of Disease" comprises a thoughtful analysis of the situation from the fundamental concepts to their practical impact on disease expression. Without propagandizing, the responsibility of medicine to society is forcibly evolved. Arresting statements are encountered; for example, "All malnutrition is social"; "In a sense, the economic system is the cardiovascular system of society." The reviewer commends this section to the careful study of all thinking physicians in this country.

The general topics proceed to genetics, "The Patient as a Person," nutrition, neoplasia, and then certain diagnostic topics. In this transition, the cohesiveness of the earlier elements is somewhat lost, even though the several considerations are independently sound and effective. Psychological and psychiatric considerations occupy a solid block of 202 pages, which will prove very timely in the light of modern medical thought and practice.

The organization of the remainder of the text requires careful thought, since there are many departures from the standard manner of approach. The endocrine disorders are given less attention than is the rule. Interestingly, the Robinson–Power–Kepler test for adrenal insufficiency is given full consideration, whereas the eosinopenia upon the administration of adrenocorticotrophic hormone is not mentioned. Conforming to the British custom, dermatology receives much more consideration than in American texts on general medicine.

The reviewer finds it difficult to reconcile the manner of handling the infectious diseases. Admittedly, one is hard pressed to deal with this vast field without crossing certain lines, but it is disconcerting to find measles and whooping cough listed under "Acute Respiratory Infections," followed in the next chapter by diphtheria. The remaining considerations of the infections of the respiratory tract are adequately met in the section "Diseases of the Respiratory System." In the chapter entitled "Miscellaneous Group," typhus fever, Weil's disease, and glandular fever are considered. In general, such artificial divisions are misleading in their lack of cohesiveness. Certainly from the standpoint of the American student, Rocky Mountain spotted fever (which is not geographically confined to western states) and rickettsialpox deserve serious consideration. Tsutsugamushi fever is not mentioned, whereas Q fever is considered in the discussion of the respiratory system. In general, these small points of limitation or omission may be overlooked in the broad scope of the text.

Forty representative physicians have contributed to this new textbook. Unquestionably, better balance will appear in later editions. One is impressed by the high quality of the several sections and the conscious effort to direct medical thought into less familiar channels. Time and experience will answer the effectiveness of this laudable design. The workmanship in format and printing is excellent. The reproduction of x-rays is, as a rule, superior to that of the other illustrations. A certain redundancy in the x-rays is encountered in some areas, but the x-rays of the chest are reproduced in remarkable detail. The contributors and editors should be congratulated on the omission of eponyms. On the other hand, there is some disconcerting confusion in the use of apothecaries' and metric systems on the same page, and sometimes in the same paragraph. Too frequently there are no bracketed equivalents.

An appeal is made for a reconsideration of the designation of the fever in Hodgkin's disease as Pel-Ebstein (page 948). Pel described this phenomenon in 1885 and Ebstein in 1887. Murchison had afforded an adequate description in 1870; but, to avoid all question of priority and eponyms in the same stroke, Gowers' designation, alternating pyrexia, might be utilized. This highly descriptive term was used by Gowers in this relation in Reynold's *System of Medicine*, published in 1879. Obviously, it is impossible to keep pace with the rapid advance of therapy in these times; but in only a few particulars does this textbook lag in this respect.

Garland and Phillips' *Medicine* strikes a new note in textbooks in this field. Its emphasis on the humanistic, sociological, and psychological aspects of medical practice will recommend it to every thoughtful student and practitioner. Its favor will depend largely upon these elements, sound as is the coverage in the general field of medicine.—W.S.M.

Psychiatry and Medical Education. Report of the 1951 Conference on Psychiatric Education held at Cornell University, Ithaca, New York, June 21–27, 1951. Organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. Washington, D. C., American Psychiatric Association, 1952.

The title of this book suggests that it might very well interest only the psychiatrist. Actually it will interest any reader, lay or professional, who is concerned with the direction medical education is taking in its effort to train physicians to meet human needs and ameliorate suffering more adequately. The thinking recorded in this volume is among the most fascinating this reviewer has encountered in the general area of medical education.

Part of the reason for this enthusiastic recommendation is that there is a relative absence of the familiar mind–body dualism in this book. All of the participants, whether psychiatrists, internists, or medical administrators, focus their attention upon the human being as a functioning whole, upon all of his suffering, and on the physician in his most inclusive role of relieving this suffering. As would be expected, therefore, psychiatry and psychiatric principles are discussed in their impact on all of medicine and all of medical education, not as a separate "discipline." Specifically, this orientation leads to a consideration of such generally important subjects as the doctor-patient relationship, personality structure and its determinative role in the patient's reaction to organic disease, human ecology ("the interaction of the human organism with human environment"), and the most effective ways that this information can be communicated to the fledgling physician. The reader will find few formulas here for the solution of these problems, but he will find himself with an increased awareness both of their extent and of their importance. Moreover, he will probably find himself spontaneously thinking toward their solution.—R.R.

Corporal
Rodolfo P. Hernandez, U.S. Army
Medal of Honor

0200 HOURS! Suddenly the pre-dawn blackness on Hill 420 split into crashing geysers of flame. Yelling, firing, hurling grenades, a horde of Reds pushed up the hill toward G Company.

A hot fire fight began, lasting several hours. Finally, suffering heavy casualties, G Company began to withdraw. Corporal Hernandez stayed, throwing grenades and firing his remaining rounds.

Then his M-1 jammed. Fixing his bayonet, he leaped out of his foxhole and disappeared in the darkness toward the attacking Reds. They found him in the morning, wounded, ringed with enemy dead. But he had stopped the attack—*alone.*

"A man couldn't fight at all," says Corporal Hernandez, "if he weren't fighting for good things—peace and a job, and a chance in the world. That's why I'm thankful to the people who've put so many billions into Defense Bonds. For I believe Bonds are a stockpile of prosperity for our country. A guarantee to men like me that we can come home to a secure future."

Peace is for the strong!
For peace and prosperity save with U. S. Defense Bonds!

Now E Bonds pay 3%! Now, improved Series E Bonds start paying interest after 6 months. And average 3% interest, compounded semiannually when held to maturity. Also, all *maturing* E Bonds automatically *go on* earning—at the new rate—for 10 *more* years. Today, start investing in U.S. Series E Defense Bonds through the Payroll Savings Plan; you can sign up to save as little as $2.00 a payday if you wish.

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

FOR SALE: 30 ma Continental x-ray and vertical fluoroscope, used, shock proof. Accessories include tank, hand timer, and cassette holder. Address replies to Box 517 in care of the Journal.

FOR SALE: Office equipment and instruments of a recently deceased Wisconsin physician. Address replies to Box 518 in care of the Journal.

FOR SALE, by widow of physician, examination table, office desk, and an assortment of instruments. Address replies to Box 519 in care of the Journal.

OPHTHALMOLOGY LOCATION WANTED: UW graduate, returning to Wisconsin for family and business reasons, wishes association with board member ophthalmologist. Training includes 3-year residency in EENT and basic science course in eye followed by several years of EENT practice. Could give excellent office and surgical assistance. Arrangements of association open. Address replies to Box 508 in care of the Journal.

EENT OFFICE FOR SALE OR RENT in community of 5,000 in east central Wisconsin. Owner retiring after 50 years of practice. Excellent 50-bed hospital. No charge for good will or introduction. Wonderful chance for right man. Address replies to Box 509 in care of the Journal.

GENERAL PRACTITIONER BADLY NEEDED in Adams–Friendship. Large practice with little competition. Local incorporated association ready to provide backing. Railroad guarantees at least $2,000 a year. Office and home available and rent free for 3 months. Hospital with ambulance facilities near by. Contact Harold T. Johnson, Adams, Wis.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately. Write Box 505 in care of the Journal.

FOR SALE: Spencer microscope in carrier. Also other physician's instruments. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

MD WANTED for small group operating clinic and 25-bed modern hospital in rural town close to large city in southwest Wisconsin. $12,000 minimum first year, then partnership. Qualifications should include enough surgical experience to cope with accidents and major surgical emergencies. Excellent modern house available. Send details in first letter to Box 506 in care of the Journal

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WANTED: General practitioner to join two-man group in thriving midwestern Wisconsin college community. Salary guaranteed first year, then partnership; new modern hospital facilities available. Address replies to Box 510 in care of the Journal.

PHYSICIAN-SURGEON WANTED: To associate with a long established 3-man fully equipped clinic. City of 4,000 with class A hospital connections. Surgical experience preferred. Percentage, salary, and partnership. Address replies to Box 514 in care of the Journal.

FOR SALE: Office equipment of general practitioner including mobile GE, D-2 model, x-ray unit and accessories; microscope; instruments; sterilizer; scales; instrument and drug cabinets; and office furniture. Address replies to Box 511 in care of the Journal.

PHYSICIAN-SURGEON WANTED for industrial community serving 3,000 people within a 20 mile area. We will lease attractive doctor's residence and a fully equipped small first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year of practice and should increase each year thereafter. Available for immediate occupancy. Call or write the Goodman Lumber Company, Goodman, Wis.

FOR SALE OR EXCHANGE: Central Wisconsin practice of retiring physician and surgeon in very desirable, prosperous rural community. Finest modern hospital facilities available. Doctors have practiced from this location for over 45 years. Property includes brick home, office facilities, waiting room, dispensary, and two-car brick garage. The lot is approximately 80 by 180, wooded and landscaped. Office equipment, instruments, etc., if desired. Financing available. Address replies to Box 512 in care of the Journal.

OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

RADIOLOGIST who completed residency July 1 available for association, hospital, or group. Will consider part-time work within commuting distance of Milwaukee. Address replies to J. E. Abrams, M. D., 2641 N. 48th St., Milwaukee 10, Wis.

WANTED: Young, progressive clinic in western Wisconsin needs pediatrician, certified or board qualified, and a general practitioner. Excellent opportunity. Address replies to Box 521 in care of the Journal.

AVAILABLE AT ONCE: Established general practice in small town in west central Wisconsin, heart of the fishing and hunting country. Owner has gone overseas with Army. Ample income from surrounding territory. Small hospital within 12 miles. Completely equipped suite of offices in part of large, newly decorated home with spacious grounds overlooking small lake. Reasonably priced for quick sale. Excellent opportunity for young physician. Address replies to Mrs. G. Mitchell, Merrillan, Wis.

FOR SALE: Practice and fully equipped 15-room office in central Wisconsin college town of 6,000. Gross over $40,000. New open hospital in city. Excellent for 3-man group. Because of health, owner will remain on part-time basis only. Address replies to Box 522 in care of the Journal.

WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

FOR SALE: Office building of late Dr. C. F. Peterson in Independence. Tile veneered, 21 by 46 ft., full basement, oil furnace. Beauty parlor upstairs could be converted into apartment. A few instruments for sale. Records go with instruments. Adddess replies to Box 524 in care of the Journal.

FOR SALE: Mobile 30 ma shockproof x-ray unit. Jones basal metabolism unit in excellent condition. Direct-writing electrocardiograph. Microscopes, new and used. Assorted cassettes with intensifying screens. Surplus x-ray filter grids, never used. FCC-approved short-wave diathermy units. Slightly used film filing cabinet. Write C. C. Remington, 1204 W. Walnut Street, Milwaukee.

INSTITUTIONAL position wanted by woman physician. Well trained in psychiatry, including shock treatments. Wisconsin license. Address replies to Box 525 in care of the Journal.

FOR RENT: Large one-room office suitable for consultant, particularly a psychiatrist, on one-day-a-week basis or full-time if desired. Active community in south central Wisconsin, with drawing population of 50,000. Office in professional building, has private bathroom and walk-in storage closet. Reasonable rental. Address replies to Box 526 in care of the Journal.

Your Visit to Milwaukee

Is Made More Enjoyable by
Stopping at the SCHROEDER

Metropolitan atmosphere
Cocktail Lounge
Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures "*know-how*"

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 6-1021

An Antihistamine of
PROVED SERVICE

For symptomatic relief of allergic disorders.

25 mg. tablets—dependable, efficient.

PYRILAMINE
MALEATE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

PAUL B. ELDER COMPANY
BRYAN, OHIO, U.S.A.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer- Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	8, 9, 23
American Meat Institute	21
Ames Company, Inc.	16
Ar-Ex Cosmetics	39
Audiphone Utilities	36
Ayerst, McKenna & Harrison, Ltd.	18
Baker Laboratories	6
Barr X-Ray Company	35
Bayer Company	20
Benson Optical Company	38
Bergmann Prescription Center	29
Camel Cigarettes	17
Central Drug	29
Ciba Pharmaceutical Products, Inc.	27
Cook County Graduate School of Medicine	5
Doerflinger Artificial Limb Co.	38
Elder, Paul B., Co.	45
Endocrine Laboratories	35
Hotel Schroeder	45
House of Bidwell	36
Hurley X-Ray Company	36
Keeley Institute	34
Kennedy–Mansfield	29
Knox Gelatine	37
Lederle Laboratories	facing page 18
Lilly, Eli and Company	22
Mallard, Incorporated	10
Mallatt Pharmacy	29
Mather Pharmacy	29
Mayer Drug	29
Mead Johnson and Company	49
Medical Protective Company	45
Merck and Company	7
Milwaukee Sanitarium	50
New York Polyclinic	39
Nichols, John, Inc.	531
Orthopedic Appliance Company	35
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	13
Physicians & Hospitals Supply Co., Inc.	12
Physicians Casualty Association	40
Professional Business Service	529
Quincy X-Ray & Radium Labs.	40
Radium Emanation Corporation	31
Rennebohm's	29
Rogers Memorial Sanitarium	50
Sacred Heart Sanitarium	4
St. Croixdale Sanitarium	5
Schering Corporation	11
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	33
Summit Hospital	31
Time Insurance Company	527
Upjohn Company	15
Winthrop–Stearns, Inc.	14
Wisconsin Life Insurance Company	5

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

J. C. GRIFFITH, Milwaukee, President
H. KENT TENNEY, Madison, President-Elect
G. E. FORKIN, Menasha, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1953
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
E. E. Kidder_____Stevens Point
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1953
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1953
A. H. Heidner_____West Bend
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
D. J. Twohig, Fond du Lac, 1953

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. F. Boock 119½ Front Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	N. E. Bear Monroe	D. E. Mings Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorensteln 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dalley Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette-Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	D. M. Bailey Gillette	G. R. Sandgren Suring	
Oneida-Vilas	M. J. Donohue Antigo	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce-St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price-Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	W. J. Schutz 123 E. Division Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau-Jackson-Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Fourth Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington-Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August. ** Except July and August.

ENTURY LATER—STILL UNEXCELLED

Pitocin®

oxytocic of choice

The isolation of PITOCIN by Parke, Davis & Company in 1927 and its introduction to the medical profession in 1928, marked a new era in hormone therapy. To the obstetrician this was an epochal event; he could now secure the desired uterine effect without the elevation of blood pressure caused by unfractionated posterior pituitary extracts.

Today, PITOCIN is still the oxytocic of choice, widely used in treatment for primary and for secondary uterine inertia, for postpartum hemorrhage due to uterine atony, for the third stage of labor, for induction of labor, and during cesarean section to facilitate suturing the uterine wall.

PITOCIN (oxytocin injection, Parke-Davis) is supplied in 0.5-cc. (5-unit) ampoules, and in 1-cc. (10-unit) ampoules, in boxes of 6, 25, and 100. Each cc. contains 10 international oxytocic units (U.S.P. units).

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE WISCONSIN MEDICAL JOURNAL

Volume 52
Number 10

MADISON, WISCONSIN, OCTOBER 1953

Per Year $5.00
Single Copy 50 Cents
Previous Years' $1.00

TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

Mesenteric Vascular Occlusion, by Albon W. Overgard, M. D., and J. W. Johnson, M. D. ---- 541

Aerosol Therapy in Children, by Frank C. Stiles, M. D. ---- 543

Skiing and Heart Strain, by Arthur Andrews Holbrook, M. D. ---- 546

Development of Health Examination Programs for Employees of Wisconsin Schools, by A. A. Pleyte, M. D., and Duane Sternitsky ---- 549

Comments on Treatment ---- 553

Clinicopathologic Conference ---- 555

Chest X-Raying of General Hospital Admissions ---- 562

MISCELLANY

Schedule of Programs of the "March of Medicine" 552

Committee Concentrates ---- 563

Facts about Blue Shield of Wisconsin ---- 564

Minutes of the Council Meeting, Madison, May 23 and 24, 1953 ---- 573

Page

H. Kent Tenney, M. D., President, 1953–1954 ---- 583

Society Proceedings ---- 20

News Items and Personals ---- 20

Third and Twelfth Districts News ---- 26

Society Records ---- 28

Marriages ---- 28

Deaths ---- 28

Correspondence ---- 31

AMA News Notes ---- 35

The Journal Bookshelf ---- 36

Physicians' Exchange ---- 42

Officers of Sections of the State Medical Society ---- 44

Index to Advertisers ---- 44

List of Officers and Scheduled Meetings of County Medical Societies ---- 45

EDITORIALS

How Much Will It Cost? ---- 582

The Wisconsin Press–Commentator ---- 584

[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress, March 3rd, 1879. Transferred to Madison, August 1st, 1929, published monthly.]
"Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918."
Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

MAIN BUILDING—One of 8 Units in "Cottage Plan"

A MODERN PRIVATE SANITARIUM

for the Diagnosis, Care and Treatment of Nervous and Mental Disorders

ST. CROIXDALE ON LAKE ST. CROIX

PRESCOTT, WISCONSIN

Located on beautiful Lake St. Croix, 18 miles from the Twin Cities, it has the advantages of both City and Country. Every facility for treatment provided, including recreational activities and occupational-therapy under trained personnel. Close personal supervision given patients, and modern methods of therapy employed. Inspection and cooperation by reputable physicians invited. Rates very reasonable. Illustrated folder on request.

Prescott Office
Prescott, Wisconsin
Howard J. Laney, M.D.
Tel. 39 and Res., 76

Consulting Neuro-Psychiatrists
Hewitt B. Hannah, M.D. : Andrew J. Leemhuis, M.D.
511 Medical Arts Bldg., Tel. MAin 1357, Minneapolis, Minn.

Superintendent
Ella M. Leseman
Prescott, Wisconsin
Tel. 69

Your Visit to Milwaukee

Is Made More Enjoyable by Stopping at the SCHROEDER

Metropolitan atmosphere

Cocktail Lounge

Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room

Music and Dancing—At Lunch, Dinner, After Theatre

Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER

MILWAUKEE

WALTER SCHROEDER, President

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting October 12, October 26, November 9

Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26

Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 9

Gallbladder Surgery, Ten Hours, starting October 26

General Surgery, Two Weeks, starting October 12

Surgery of Colon & Rectum, One Week, starting October 26

Thoracic Surgery, One Week, starting October 12

Esophageal Surgery, One Week, starting October 19

Breast & Thyroid Surgery, One Week, starting October 26

Fractures & Traumatic Surgery, Two Weeks, starting October 26

GYNECOLOGY—Intensive Course, Two Weeks, starting October 19

Vaginal Approach to Pelvic Surgery, One Week, starting November 2

OBSTETRICS—Intensive Course, Two Weeks, starting November 2

MEDICINE—Electrocardiograhy & Heart Disease, Two Weeks, starting October 12

Gastroenterology, Two Weeks, starting October 26

Gastroscopy, Two Weeks, starting November 2

DIAGNOSTIC X-RAY—Clinical Course every week by appointment

CYSTOSCOPY—Ten day practical course starting every two weeks

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

A Wise Choice Against Resistant Coc

ERYTHROCIN

a selective antibiotic

A DRUG OF CHOICE

inst the majority of coccic infections—especially when ients are sensitive to other antibiotics or the cocci are stant.

DRUG OF CHOICE

inst staphylococci—because of the high incidence of phylococcic resistance to other antibiotics.

A DRUG OF CHOICE

cause it is less likely to alter normal intestinal flora n other oral antibiotics, except penicillin; gastrointinal disturbances are rare; no serious side effects orted.

ADVANTAGEOUS

because the special acid-resistant coating, developed by Abbott, and Abbott's built-in disintegrator, assure rapid dispersal and absorption in the upper intestinal tract.

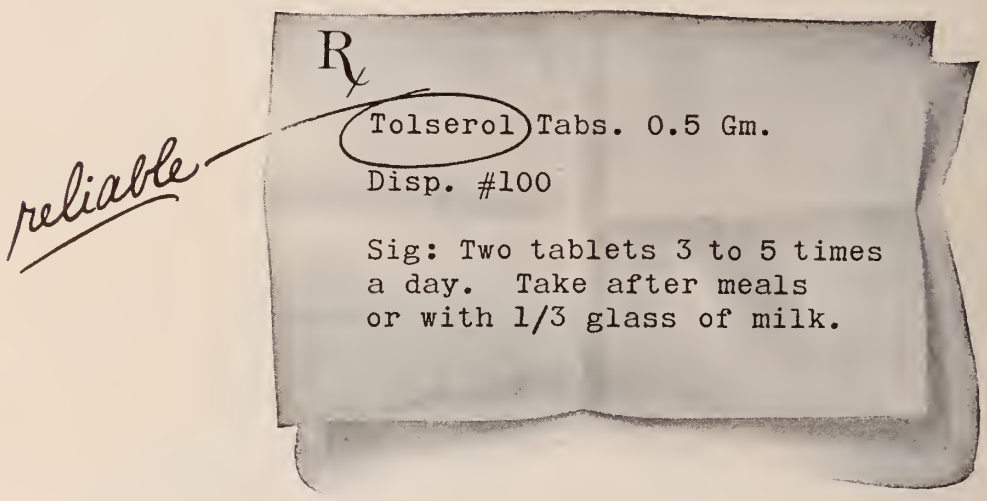
Prescribe ERYTHROCIN

in pharyngitis, tonsillitis, otitis media, sinusitis, bronchitis, pneumonia, scarlet fever, erysipelas, pyoderma, certain cases of osteomyelitis, and other indicated conditions. Abbott

* *Trade Mark for*

ERYTHROMYCIN, ABBOTT CRYSTALLINE

RAPID ABSORPTION—*MAXIMUM THERAPEUTIC EFFECT*



The clinical effectiveness of different brands of mephenesin tablets depends on their rate of absorption. A mephenesin tablet that disintegrates slowly is absorbed slowly. The resulting low blood levels may never produce a maximum therapeutic effect. Results with such a tablet are usually poor.

Tolserol Tablets are a result of extensive study and are formulated to disintegrate rapidly for fast absorption, thus maintaining optimum blood levels.

Tolserol

(Squibb Mephenesin)

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, in neurologic disorders and in acute alcoholism is available from the Professional Service Department, Squibb, 745 Fifth Avenue, New York 22, N. Y.

SQUIBB

Terramycin®

BRAND OF OXYTETRACYCLINE

an agent of choice in urinary tract infections

- *promptly effective against a broad-spectrum of urinary pathogens*
- *high concentration in active form in urinary tract*
- *well tolerated, even upon prolonged administration*

Terramycin is acclaimed by urologists everywhere for unsurpassed action in

chronic urinary tract infections

acute urinary tract infections

urinary tract surgery

"The resistant cases showed remarkable response."[1]

". . . has cured where all other antibiotics have failed."[2]

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[3]

"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycin."[3]

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[2]

1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.

Pfizer

PFIZER LABORATORIES BROOKLYN 6, N. Y.

DIVISION, CHAS. PFIZER & CO., INC.

50 YEARS AGO

"... in a word, deficiency of fat in the food is one of the chief factors in the production of rickets." (1)

TODAY...

We know that lack of fat-soluble vitamin D in the diet is one of the major causes of rickets. Other deficiency diseases are also caused by a lack of adequate vitamins in the diet.

POWDER and LIQUID

Made from Grade A Milk, (U. S. Public Health Service Milk Code) modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

VITAMIN CONTENT PER QUART OF NORMAL DILUTION:

Vitamin A	2500 U.S.P. Units	Thiamine	0.6 milligrams
Vitamin D	800 U.S.P. Units	Niacin	5.0 milligrams
Vitamin C	None	Riboflavin	1.0 milligrams

A source of vitamin C should be prescribed by the physician.

BAKER'S MODIFIED MILK IS FORTIFIED BY *Synthetic* VITAMINS TO PROVIDE ADEQUATE AMOUNTS OF ALL RECOMMENDED VITAMINS (except C)

(1) Cheadle—*Artificial Feeding and Food Disorders of Infants.* Sixth Edition (1906)

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland 3, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Cortisone + SCHERING = Cortogen

the symbol SCHERING denotes leadership in
steroid hormone research and
manufacture -- including Cortogen
in the most useful clinical forms.
For systemic therapy, use Cortogen
Tablets or injection.
For eye disorders use Cortogen
Ophthalmic Suspension --
Sterile. The Schering seal
appears on each tablet and package
- your assurance of quality.

CORTOGEN®

Acetate (cortisone acetate, Schering) Tablets, 5 mg. and 25 mg.;
Injection, 25 mg. per cc., 10 cc. multiple-dose vials;
Ophthalmic Suspension—*Sterile*, 0.5% and 2.5%, 5 cc. dropper bottles.

Schering CORPORATION · BLOOMFIELD, NEW JERSEY
In Canada: Schering Corporation, Ltd., Montreal.

CORTOGEN

SCHERING

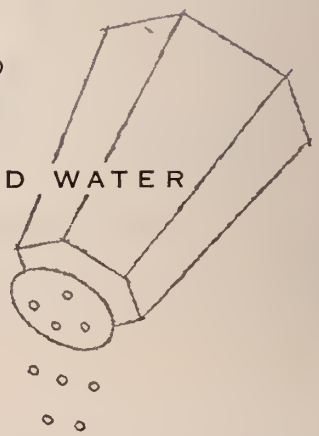
"It's so good to be back on the job, doctor"

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN

NORMAL OUTPUT OF SODIUM AND WATER



PRESCRIBE NEOHYDRIN whenever there is retention of sodium and water except in acute nephritis and intractable oliguric states. You can balance the output of salt and water against a more physiologic intake by individualizing dosage. From one to six tablets a day, as needed.

PRESCRIBE NEOHYDRIN in bottles of 50 tablets. There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea in each tablet.

Leadership in diuretic research

Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

Here's the *most comprehensive* x-ray supply catalog ever published!

No x-ray department can afford to be without General Electric's new x-ray supply catalog. Every supply and accessory item you need is covered in an easy, straight-forward manner that simplifies ordering.

And here are two unique conveniences: Prices are printed alongside every listing — there's no need to bother with a separate price list. Bound-in postpaid order cards also save time — and postage.

Ask your G-E x-ray representative for this handy reference guide to your entire x-ray supply needs.

GENERAL ELECTRIC

Direct Factory Branches:
MILWAUKEE — 547 N. 16th Street
MINNEAPOLIS — 808 Nicollet Avenue
DULUTH — 928 East 2nd Street

Resident Representatives:
GREEN BAY — J. J. Victor, P. O. Box 61
MADISON — L. J. Dorschel, 1422 Mound Street

"PREMARIN"

...*"sense of well-being"*...

In addition to relief of menopausal symptoms, "a feeling of well-being or tonic effect" was frequently reported by patients on "Premarin" therapy.*

"PREMARIN"® *in the menopause*

Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine). Tablets and liquid.

*Harding, F. E.: West. J. Surg. *52*:31 (Jan.) 1944.

5311

Ayerst®

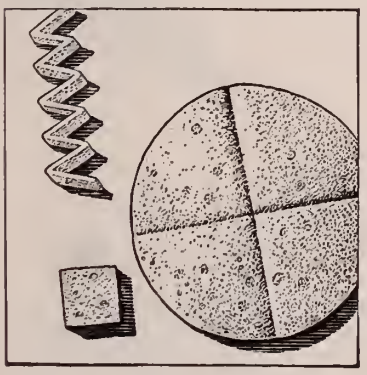
AYERST, McKENNA & HARRISON LIMITED • *New York, N. Y.* • *Montreal, Canada*

Upjohn

absorbable hemostat:

Available in a large variety of sizes and forms, including:
Surgical sponges
Compressed surgical sponges
Dental packs
Gynecologic packs
Nasal packs
Prostatectomy cones
Tumor diagnosis kit

The Upjohn Company, Kalamazoo, Michigan



Gelfoam

Trademark Reg. U.S. Pat. Off. BRAND OF ABSORBABLE GELATIN SPONGE

"THERE'S ALWAYS A

Leader. . . . . MALLARD, INC."

We'd rather get a brickbat!

You make us happy when you praise our products. Then, occasionally you suggest a modification. This brickbat is more welcome than the bouquets of praise.

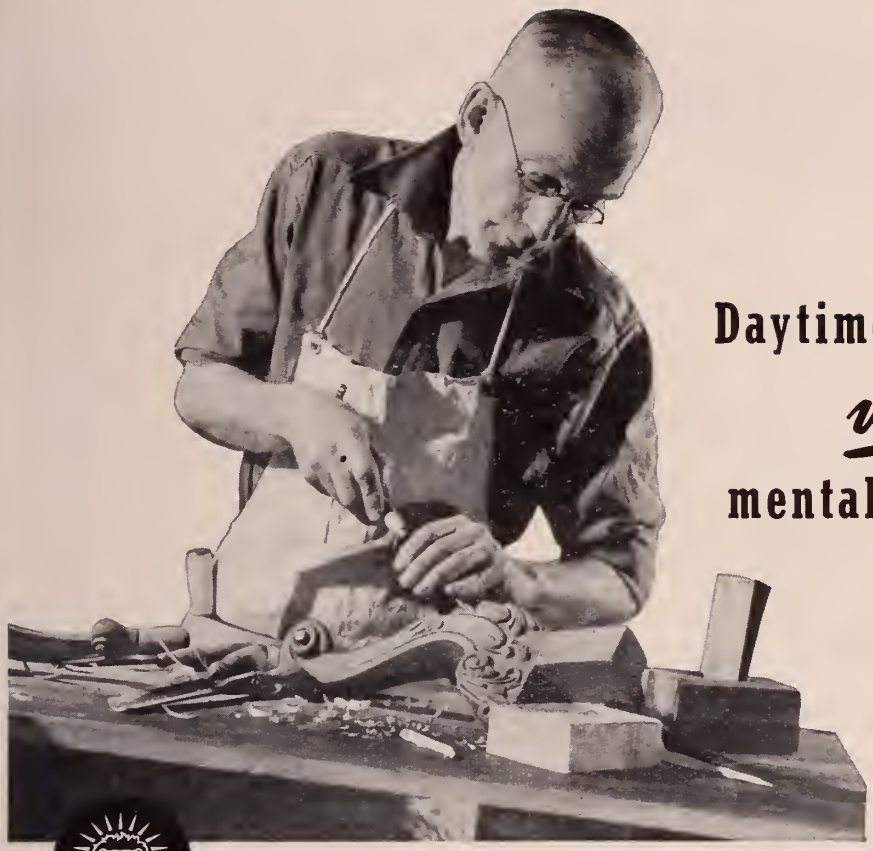
Here's why:

Only your suggestions—and all criticism is constructive if well received—tells us how our pharmaceuticals can better serve you. Our 41 years leader-ship is based on perfectly supplying your need. So, help us next time our salesman calls, by telling him everything that is on your mind.

Thank you for your confidence.

Karl O. Mallard
Karl O. Mallard, President
Mallard, Inc.

MALLARD
INC.
DETROIT 16, MICHIGAN



Daytime sedation
with
mental alertness

WINTHROP

MEBARAL®

BRAND OF MEPHOBARBITAL

—in depressed and agitated states

psychoneurosis
hypertension
hyperthyroidism
convulsive disorders
difficult menopause
hyperhidrosis

Neurotic depression hiding beneath the disguise of multiple physical complaints is an everyday problem in medical practice.

For effective sedation in these cases, and as a means of restoring harmonious relations between patient and environment, Mebaral has been found especially suitable because it lacks excessive hypnotic action.

DOSAGE:
Adults—32 mg. to 0.1 Gm. (optimal 50 mg.), 3 or 4 times daily.

Children—16 to 32 mg., 3 or 4 times daily.

SUPPLIED:
Tablets of 32 mg. (½ grain)
50 mg. (¾ grain)
0.1 Gm. (1½ grains)
0.2 Gm. (3 grains) scored

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Mebaral, trademark reg. U.S. & Canada

WINTHROP-STEARNS INC. New York 18, N.Y. • Windsor, Ont.

ILOTYCIN · ILOTYCIN · ILOTYCIN · ILOTYCIN · ILOTYCIN · ILOTYCIN · ILOTYCIN

2 Convenient dosage forms

'Ilotycin,' Crystalline, Tablets
(ERYTHROMYCIN, LILLY)
'Ilotycin Ethyl Carbonate, Crystalline'
(ERYTHROMYCIN ETHYL CARBONATE, LILLY)
Pediatric

- Taste-tested by Lilly's Junior Taste Panel, the flavor of *'Ilotycin Ethyl Carbonate, Crystalline,' Pediatric*, is sure to please your young patients—as well as adults who prefer liquid medication.
- Well tolerated—There is minimal gastric irritation, nausea, and diarrhea.
- 'Ilotycin' does not predispose to monilial superinfection or vitamin B complex deficiency.

AVERAGE DOSAGE: Thirty-pound child, 1 teaspoonful 'Ilotycin Ethyl Carbonate, Crystalline,' Pediatric, every six hours; others, in proportion to weight. Adult, 200 mg. every four to six hours.

SUPPLIED: 'Ilotycin,' Crystalline, in 100-mg. or 200-mg. specially coated tablets. 'Ilotycin Ethyl Carbonate, Crystalline, Pediatric, is supplied in 60-cc. packages. Each teaspoonful (5 cc.) contains 100 mg. of 'Ilotycin' as the ethyl carbonate.

Lilly

For successfully treating the most common bacterial infections

ILOTYCIN
(ERYTHROMYCIN, LILLY)
the Original Erythromycin

Eli Lilly and Company • Indianapolis 6, Indiana, U. S. A.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 OCTOBER 1953 Number 10

Mesenteric Vascular Occlusion

By ALBON W. OVERGARD, M. D., and J. W. JOHNSON, M. D.
Stanley Withee

MESENTERIC vascular occlusion has been recognized as a clinical entity for over 100 years.[1] In spite of the fact that surgical treatment was accomplished almost 60 years ago,[1] reports of successful treatment have been rare. Up to 1944 only 35 favorable results had been reported.[2] Since then about 45 more have been published.[1, 3-7] We wish to add another.

Case Report

On Nov. 6, 1952, a 68-year-old white male was admitted to Victory Memorial Hospital, Stanley, because of severe, constant, and boring abdominal pain of 12 hours' duration, and of vomiting for 5 hours. His temperature was 98 F., pulse 96, respirations 20, and blood pressure 112/70. Rigidity and tenderness of the upper half of the abdomen were noted. The urinalysis and blood count were normal, except for 1-plus acetone and a white blood cell count of 15,600. A diagnosis of acute surgical abdomen was made, with perforated gastric ulcer considered as the most likely cause.

Shortly after admission a laparotomy was performed using an upper right rectus incision. The jejunum appeared markedly distended and engorged. At the beginning of the ileum an area approximately three feet long of gangrenous bowel due to mesenteric thrombosis was found. This portion of ileum, with about eight inches of apparently normal bowel on each end, was resected and an aseptic end-to-end anastomosis performed. Considerable serosanguineous fluid was removed from the abdominal cavity by suction, and neomycin was instilled. During surgery 500 cc. of whole blood was given and the patient left the operating room in good condition.

On the patient's return to his room continuous oxygen was administered and 200 mg. of depo-heparin given. The depo-heparin was repeated daily until the eighteenth postoperative day except for two days. The postoperative course was surprisingly smooth. Wangensteen suction was used continuously for the first four days and thereafter intermittently for the next three or four days. One cubic centimeter of Prostigmin was given intramuscularly four times daily for 10 days and the rectal tube was used as necessary. A hard, foul-smelling stool was passed on the third postoperative day and thereafter the patient had daily passages of liquid to semi-solid stools. He received approximately 3,000 cc. of fluids on each of the first three days, 2,000 cc. daily for the next four days, and occasionally Ringer's solution. After one week this was discontinued. On the fifth day he was able to retain small amounts of liquids by mouth.

Fifteen days after undergoing surgery the patient left the hospital with instructions to continue on a bland diet for the next few weeks. He had lost 25 lb. while in the hospital but within a month this weight was regained. Three weeks after leaving the hospital he began doing the farm chores. At the present time (four months postoperative) he is able to work as hard as usual, can eat anything he wants, and feels no ill effect from the surgical procedure he underwent.

Discussion

The etiology of mesenteric vascular occlusion is usually obscure.[5] In our patient no explanation was found. Occasionally it can be related to conditions which give rise to emboli or favor thrombosis of the mesenteric vessels, such as cardiovascular disease, he-

matologic diseases, and intra-abdominal infections producing mesenteric thrombophlebitis and trauma to the mesenteric vessels, particularly at the time of operation and during the incarceration of a hernia.[8] It is an extremely rare condition and was reported as occuring only 44 times among the 41,982 surgical admissions over a period of 10 years at the Michael Reese Hospital.[9] At the Tauro Infirmary[7] only 19 instances occurred in 55,232 surgical admissions. It is more common in males and may occur at any age, though it is most frequently seen in patients from 30 to 70 years of age.

The preoperative diagnosis is seldom made, because the onset, course, and physical findings are similar to those seen in other types of acute abdominal conditions. The presence of predisposing factors, such as those listed in the preceding paragraph, together with the history and findings that are not typical of the more frequently observed acute diseases, should suggest it.

The treatment is immediate surgery. Resection of the bowel down to its root is the recommended procedure. This should be attempted in all cases, even though the outlook may be grave, since the mortality is 100 per cent without resection. Exteriorization of the affected bowel has been uniformly fatal. As much as 30 per cent of the small intestine has been resected with favorable results.

The postoperative treatment must be adequate and carefully planned. Maintenance of fluid and electrolyte balance and the judicious use of antibiotics and anticoagulants are essential. The prognosis is poor under the best of circumstances. Surgical mortality is as high as 90 per cent.[9]

In the past the surgical mortality was uniformly high, but in recent years the outcome has presented a much brighter picture, owing in large part to improved methods of supportive therapy. As recently as 1942 the following statement was printed: "This disease is almost universally fatal. Reports of recovery should be regarded with suspicion."[10] Whittaker and Pemberton[11] gave a detailed report on 60 cases seen at their clinic before 1938. Only 19 (31.6 per cent) of these patients underwent surgery and 16 of this group died, an operative mortality of 84.2 per cent. The remaining 41 patients were not operated on and all died. In the past 11 years 24 patients who had proved mesenteric vascular occlusion have been seen at their clinic and 13 of these have undergone operation, an operability rate of 54.1 per cent. Therefore, during the past 11 years the operability rate at their clinic was increased by 22 per cent. Of the 13 patients who were operated on, 10 survived, a surgical mortality rate of 23 per cent. The other 11 patients were not operated on because of their extremely poor condition and lack of response to intensive supportive therapy. The mortality rate in this group was 100 per cent.

Summary

We have reported the successful surgical treatment of mesenteric vascular occlusion in a 68-year-old male. Over four feet of the ileum was removed. This extremely rare condition has been reported about 600 times, and only 75 or 80 successfully resected cases are on record. The mortality is 100 per cent without surgery. Even with early surgery and adequate preoperative and postoperative care, the survival rate is low.

(A.W.O.) 204½ North Broadway

REFERENCES

1. Strohl, E. L., and Lasner, J.: Mesenteric vascular occlusion, Arch. Surg. 60:339–342 (Feb.) 1950.
2. Ficarra, B. J.: Mesenteric vascular occlusion; presentation of 15 cases, Am. J. Surg. 66:168–177 (Nov.) 1944.
3. Musgrove, J. E., and Seybold, W. D.: Symposium on abdominal surgery; mesenteric vascular occlusion, S. Clin. North America 30:1063–1071 (Aug.) 1950.
4. McCune, W. S., Keshishian, J. M., and Blades, B. B.: Mesenteric thrombosis following blunt abdominal trauma, Ann. Surg. 135:606–614 (May) 1952.
5. Knepper, P. A., McDaniel, J. R., Brooker, R. M., and Neudorff, L. G.: Primary mesenteric thrombosis treated with resection and anticoagulants, Am. J. Surg. 80:937–940 (Dec.) 1950.
6. Rives, J. D., Strug, L. H., and Essrig, I. M.: Mesenteric vascular occlusion, Ann. Surg. 127: 887–906 (May) 1948.
7. Storer, J., Kazdan, P., and Bilton, J. L.: Venous mesenteric thrombosis; suggested etiology and case report, Am. J. Surg. 84: 636–640 (Dec.) 1952.
8. Warren, S., and Eberhard, T. P.: Mesenteric venous thrombosis, Surg., Gynec., & Obst. 61: 102–121 (July) 1935.
9. Laufman, H., and Scheinberg, S.: Arterial and venous mesenteric occlusion; analysis of 44 cases, Am. J. Surg. 58: 89–92 (Oct.) 1942.
10. Christopher, F., editor: A Textbook of Surgery. By American Authors, ed. 3, Philadelphia, W. B. Saunders Company, 1942, pp. 1081–1082.
11. Whittaker, L. D., and Pemberton, J. de J.: Mesenteric vascular occlusion, J. A. M. A. 111: 21–24 (July 2) 1938.

Aerosol Therapy in Children

By FRANK C. STILES, M.D.
Monroe

RENEWED interest in aerosol therapy has been created by the publication of several recent reports. The purpose of this paper is to point out some of the indications and advantages of aerosol therapy and to discuss a simplified procedure of giving such therapy.

Aerosol antibiotic administration is well known and commonly employed. Penicillin and streptomycin are particularly well suited for dispersion in the respiratory tract by such means.* Recently the wetting agents have been employed as solvents for antibiotics, as agents to increase the effectiveness of steam inhalation therapy, in the treatment of specific conditions characterized by the presence of thickened bronchial secretions, and as an aid in expanding collapsed lung tissue.[1] A mixture such as Alevaire** contains distilled water as a source of cold steam, glycerine to prevent evaporation, and a wetting agent, "triton WR-1339."[1, 2] Other preparations such as ephedrine, insulin, antihistamines, and estrogens have been used by inhalation.

Therapy by means of aerosol mist inhalation has been employed for such conditions as asthmatic bronchitis, laryngotracheobronchitis, congenital atelectasis of the lung, acquired and spontaneous pneumothorax, laryngeal stridor, bronchitis, bronchopneumonia, bronchiectasis, tuberculosis, pertussis, mucoviscidosis, kerosene poisoning, and other conditions associated with the presence of thickened secretions in the respiratory tract.[1, 3–5] Experience in the therapy of a few of these will be discussed. It must be emphasized that the sole reliance should not be placed on any form of aerosol therapy, but that additional antibacterial treatments should be given by the oral or parenteral route.

Congenital Atelectasis of the Lung. To many physicians the management of this condition has been particularly frustrating. The high mortality rate reflects the inadequacy of treatment methods in correcting this condition. Various attempts at alveolar expansion are often unsuccessful. It is known that high alveolar pressure, if applied for any length of time, can easily result in the rupture of the alveolar wall. Research is now being done on the use of higher pressures for shorter periods of time, and perhaps some new physiologic concepts and methods of treatment will evolve. The most promising approach at present seems to be the use of the aerosol administration of a wetting agent such as Alevaire.

In two cases of congenital atelectasis treated by the author, this method of therapy has seemed to be life-saving, since before the onset of therapy the infants were getting worse hour by hour. After the institution of Alevaire therapy, there was dramatic improvement. Ravenel[5] reports the treatment of 18 infants (including 8 prematures) with massive atelectasis or fluid aspiration. All 18 recovered. Aerosol therapy has proved both safe and effective. The author advocates its more general use for congenital atelectasis of the lung.

Infectious Laryngotracheobronchitis. The importance of high humidification in the treatment of this condition is well known. By the use of antibiotics given by aerosol inhalation the effectiveness of this therapy has been enhanced. Many observers believe that by such means fewer tracheotomies now need to be done.[3] The clinician must not, however, rely entirely on aerosol therapy. Patients with infectious laryngotracheobronchitis still need to be watched very closely. In the presence of marked laryngeal stridor, cyanosis, or marked respiratory difficulty, a tracheotomy must be considered. The use of Alevaire to which penicillin and streptomycin have been added has proved to be highly effective

From the Department of Pediatrics, The Monroe Clinic, Monroe, Wisconsin.

* This may be given continuously or intermittently. Three hundred thousand units of aqueous penicillin and 125 mg. of streptomycin dissolved in 7 cc. of normal saline or other solution administered every six hours would be an average dose for a 50-pound child, for example.

** Alevaire is made by Winthrop–Stearns, Inc., New York.

in the author's hands when given continuously during the acute stages of laryngotracheobronchitis.

Bronchial Asthma. Aerosol therapy with Alevaire is being tried for asthma in children. It is too early to evaluate the results. If infection or thickened secretions are absent, it is doubtful that such therapy will be superior to present methods of management of the acute asthmatic attack.

Bronchitis. Two cases of acute bronchitis in which the etiologic agent was not found have been treated satisfactorily. In most cases the additional expense of therapy and hospitalization are not warranted.

One case of chronic bronchitis was treated with dramatic improvement. A 2-year-old child who had severe chronic bronchitis of 8 months' duration was treated. The child had previously had numerous courses of various antibiotics. X-rays on several occasions showed increased hilar markings. Throat cultures on several occasions showed mixed flora with a predominance of staphylococci and beta-hemolytic streptococci. Tuberculosis and histoplasmosis had been ruled out. After three days of aerosol therapy with Alevaire, penicillin, and streptomycin, marked clinical improvement was noted. After one week a chest x-ray showed that the bronchitis had resolved.

Pertussis. There has been no chance to try aerosol therapy on cases of pertussis here. From the results in related conditions clinical trial seems justified.

Pneumonia and Pneumonia with Atelectasis. Ravenel[5] has reported on the successful treatment of 6 patients with pneumonia due to Friedländer's bacillus. Two of these patients were 6 weeks of age.

In the presence of atelectasis or plugging due to thickened mucus, the use of a wetting agent by aerosol therapy seems indicated.

Mucoviscidosis (Cystic Fibrosis of the Pancreas). The thick, tenacious bronchial secretions of the child suffering from mucoviscidosis are a great problem. Respiratory complications account for the early deaths of many of these patients. Case reports of the use of a wetting agent alone or combined with antibiotics are difficult to find. Here, however, this form of treatment should find great usefulness. While at Milwaukee Children's Hospital, the author treated a series of 6 cases of mucoviscidosis with an aerosol trypsin preparation in an attempt to "dissolve" the thick mucous plugs characteristically found in this disease. Despite intensive courses of therapy, the results were poor. Unpublished results of other workers have been similar. Antibiotics given by aerosol are often of benefit in this condition. It is probable that a combination of antibiotics plus Alevaire would prove of value for this condition.

Hyalin Membrane. The presence of hyalin membrane is more common in premature infants and infants born by cesarean section. It is probably caused either by aspiration of amniotic fluid or as a result of the presence of blood in the alveoli. Microscopically, the presence of hyalin membrane is commonly accompanied by various degrees of atelectasis. Alevaire therapy as described for congenital atelectasis might thus be employed whenever hyalin membrane is suspected. Wetting agents have not been effective in the treatment of hyalin membrane experimentally produced in guinea pigs,[5] it must be stated. Gastric lavage on all babies born by cesarean section should, of course, be done soon after delivery.

Other Conditions. An aerosol streptomycin combined with a wetting agent was employed in the treatment of tuberculosis by Miller, Abramson, and Ratner in 1948, with encouraging results.[4] The use of aerosol therapy in bronchiectasis deserves further study. Of interest recently have been the reports of the use of aerosol therapy with wetting agents in kerosene poisoning.[5] Clinical reports are just appearing and appear favorable in resolving pulmonary symptoms. Aerosol therapy has been used successfully in coping with accumulated secretions or bulbar paralysis of poliomyelitis.[5]

Mechanics of Administration. Aerosol therapy at St. Clare Hospital, Monroe, has been employed in conjunction with the "Isolette," other types of incubators, plastic oxygen hoods, and the "Croupette." Several technical difficulties have been encountered in administering aerosol therapy, especially with the wetting agents. As a result, several suggestions are made which may be of benefit to others.

An article by S. F. Ravenel[5] describes the method of production of an aerosol mist, by the method designed by Dr. J. B. Miller of

Mobile, Ala. He describes the use of a No. 40 DeVilbiss nebulizer. Two 18-gauge needles, each ½ inch long, are inserted through a small rubber stopper that fits the side vent of the nebulizer. The solution of Alevaire is dripped into the nebulizer at a rate of 10 to 20 drops per minute through the upper needle; the other needle is attached to a small rubber tubing which allows any excess solution to drain (or siphon out) and is in turn collected in a bottle near floor level. Oxygen which has not passed through water is run into the nebulizer at a rate of 4 to 8 liters per minute. The Alevaire mist is then passed through a large rubber tube into a plastic box or "Croupette" tent. One important detail is omitted in this description. The needles which are inserted through the DeVilbiss nebulizer should be bent at right angles after passing through the small rubber stopper. The needle which is connected to the overflow siphon must extend below the surface of the solution in the nebulizer; otherwise the continuous siphon effect is interrupted, and oxygen bubbles through the overflow solution. The author encountered this difficulty. The best description of the proper set-up is found in an article by Dr. J. B. Miller.[6]

Doctor Miller has recently described a new nebulizer,[7] called the "Alevizer,"* for humidification and Alevaire therapy. This may be used with incubators, humidi-cribs, etc. This apparatus is supposed to have the advantage of maintaining a constant, continuous fluid level in the nebulizer.

Another new nebulizer[8] has the trade name of Mist-O_2-Gen.** This unit would seem to have many advantages, as the construction appears rugged and there is no glass nebulizer to break (a common mishap). This apparatus is said to deliver a fine nebulized particle.

Two modifications are suggested as a result of personal experiences. First of all, the rubber tubing from the nebulizer to the oxygen hood or tent may be eliminated. A moderate amount of mist often condenses within the rubber tubing. Efficiency seems to be increased by taping the nebulizer directly to the plastic hood. Similarly, the nebulizer may be placed adjacent to or within an incubator when incubation is also desirable. Second, it is recommended that the overflow needle, tubing, and bottle be eliminated as an unnecessary complication. The nurses at our hospital had no difficulty in regulating the rate of flow so that the proper level in the atomizer was obtained. If the solution should enter the nebulizer too fast, it drips out of the outflow without affecting the mist. Finally, caution is needed to prevent any detergent solution from getting between the rubber tubing and glass, as connections will not stay intact and therapy can easily be interrupted without the nurse's knowledge.

* Obtainable from S. Cuis, 101 Providence St., Mobile, Ala.

** Mist-O_2-Gen Equipment, Division of the Production Foundry Co., 2700 Magnolia St., Oakland, Cal.

Summary

1. Indications for aerosol therapy in children are presented. Mention is made of different agents used for this therapy.

2. Experiences and reports of therapy are presented. The use in congenital atelectasis of the lung in newborns, laryngotracheobronchitis, chronic bronchitis, mucoviscidosis, and kerosene poisoning is stressed.

3. Reliance on aerosol therapy alone should not occur. Intelligent antibiotic therapy by the oral or parenteral route should be used concomitantly.

4. Some practical aspects of therapy are discussed. Modifications of present technics are suggested.

The Monroe Clinic.

REFERENCES

1. Miller, J. B., and Boyer, E. H.: A nontoxic detergent for aerosol use in dissolving viscid bronchopulmonary secretions, J. Pediat. 40: 767–771 (June) 1952.
2. Hall, G. C., Jr.: Pulmonary toxicity of wetting agents dispensed as aerosols, Am. J. Dis. Child. 80: 408–412 (Sept.) 1950.
3. Romansky, M. J., and Kelser, G. A.: Antibiotic and chemotherapeutic agents in infections of the respiratory tract, J. A. M. A. 150: 1447–1449 (Dec. 13) 1952.
4. Miller, J. B., Abramson, H. A., and Ratner, B.: Aerosol streptomycin treatment of advanced pulmonary tuberculosis in children, Am. J. Dis. Child. 80: 207–237 (Aug.) 1950.
5. Ravenel, S. F.: New technique of humidification in pediatrics, J. A. M. A. 151: 707–711 (Feb. 28) 1953.
6. Miller, J. B.: Apparatus for prolonged continuous aerosol administration, Am. J. Dis. Child. 84: 616–621 (Nov.) 1952.
7. Miller, J. B.: A new continuous nebulizer (alevizer) for humidification and Alevaire therapy, J. Pediat. 42: 721–725 (June) 1953.

Skiing and Heart Strain*

By ARTHUR ANDREWS HOLBROOK, M.D.
Milwaukee

SKIING at high altitudes subjects the heart to the same types of strain as are employed in the "Anoxemia Test" of Levy and the "Two-step Test" of Master. Besides low oxygen tension and exertion, other factors can precipitate attacks of angina pectoris in susceptible individuals. These factors include breathing cold air, especially the cold wind incident to the downhill run, and the excitement and emotional stresses from which neither expert nor beginner is immune. The net result of these factors is a strain on the heart, since the demand for oxygen by the myocardium is greater than the coronary arteries can supply. When the amount of oxygen is inadequate, ischemia results. Depending upon the degree of ischemia, changes in the T-waves of the electrocardiogram usually occur, and the patient may experience pain. If the hypoxic state of the myocardium is profound and persistent, organic damage may involve focal areas and produce deviations in the RS-T segments of the electrocardiogram, the so-called "strain pattern." It is not this kind of injury that I wish to imply by the word "strain." I use it rather in the sense of "to put to great stress or effort."

Considering now the manner in which altitude imposes its strain, we must consider a few basic principles of physics. Dry atmospheric air exerts the following pressures at stated elevations: 760 mm. of mercury at sea level, 560 mm. at 8,000 ft., and about 400 mm. at 16,000 ft. Since oxygen constitutes 20.96 per cent of air regardless of altitude, it is apparent that its partial pressure falls in direct proportion to the above figures. In translating this loss of pressure at ascending altitudes into terms of the composition of air at sea level, we find that the value of oxygen at 8,000 ft. has dropped from 20.96 per cent to 15.4 per cent, at 12,000 ft. to 13.2 per cent, and at 16,000 ft. to about 11 per cent. The "Anoxemia Test" of Levy calls for the administration of 10 per cent oxygen for 20 minutes to the examinee lying in bed. This is considered to be as severe a strain as may properly be imposed under controlled conditions. The same effect could be achieved by breathing atmospheric air at 18,000 ft. When we realize that the skier at about 8,000 ft. has only 5 per cent more oxygen than the rigorous test allows, it is apparent that altitude *per se* is an important factor bearing on cardiac function.

The other major consideration, the effect of exercise on the heart, has been the subject of a number of articles in the literature which are worth reviewing briefly. In 1936, Suzman and Jokl[1] described observations made on a 21-year-old man who ran 26 miles in 2¾ hours at 5,000 ft. above sea level. No significant electrocardiographic changes occurred in the standard leads which were taken before and after the race. The control pulse rate was 60; 5 minutes after the finish, the rate was 125. The authors remarked that less well-trained marathon runners usually develop pulse rates of at least 180 by the end of a race.

Jokl has been particularly interested in cases of "acute, fatal, non-traumatic collapse" associated with physical exertion. In 1940, he and Melzer[2] discussed 63 such cases, among which there was not a single instance of death due to the effects of extreme exertion upon a healthy heart and aorta. The causes of death were attributable to coronary arteriosclerosis, rupture of an aortic aneurysm, vegetative endocarditis, myocarditis, and other vascular diseases. Conspicuously lacking from this list was valvular disease of the heart. Many examples of outstanding athletic prowess in the presence of aortic and/or mitral disease have been cited by Jokl.[3, 4] He stated that there is no known case of valvular disease affecting an otherwise healthy heart in which death occurred suddenly during exertion.

The results of electrocardiograms done on 650 Finnish athletes were reported by Klemola[5] in 1951. The 11 skiers in the group

* Presented at the annual meeting of the Northwestern Medical Association, February 18, 1953, Sun Valley, Idaho.

The experimental studies were supported by a grant from the Fund for Scientific Advancement and Education, Columbia Hospital, Milwaukee, Wisconsin.

showed an average pulse rate of 52, whereas the rates for 13 cross country runners and 53 cyclists were 56 and 57 respectively. This study was conducted over a period of 20 years. One of the interesting conclusions was that athletes specializing in events requiring tenacity tend to increase their P-R intervals by training. The phenomenon is reversible.

A paper from the department of physiology, Central Gymnastic Institute, Stockholm, entitled the "Physiology of Skiing,"[6] presented interesting data on the oxygen consumption of skiers in action. Most of the experiments were done on a horizontal track. It was concluded that this type of exercise is particularly effective in conditioning the respiratory and cardiovascular systems for any kind of competitive sport. The observation was made that in skiing "the feeling of exertion at a given 0_2-consumption is decidedly less than with most other types of exercise." For this reason older people should beware of overstraining themselves unwittingly while skiing.

There are situations in the sport of skiing in which any one of us may extend himself physically. The expert does it in racing, the beginner in falling down and getting up repeatedly, the average skier in trying to follow someone who is more proficient. In an attempt to discover what spurts of violent exercise do to us electrocardiographically, I conducted a study in which electrocardiograms were taken on a group before and after playing squash. It seemed to me that from the point of view of exertion a hard game of squash has much in common with, for example, a fast slalom run.

There were seven men in the series, all of whom had played the game for years. Their ages were 28, 32, 42, 42, 43, 45, and 46 years. Four-game matches were played in about one-half hour at each session. The first tests were run at the beginning of the season in November. Five of the players were retested about three months later with the idea of evaluating possible influences of training.

The technic of the procedure was simple. Two direct-writing electrocardiographic machines were set up in the locker room adjoining the squash courts. The subjects were tested in the reclining position. Electrocardiograms were made immediately before and after each match and then at 5-minute intervals for 2 or 3 more times. The standard leads and Cf_4 were employed. The tracings were measured and charted for changes in 3 items—heart rate, T-waves, and RS-T segments.

The following pertinent facts emerged from the mass of data gathered in the 12 experiments:

1. The average heart rate for the series increased from a control figure of 66 to 109 immediately after exertion.
2. There were no RS-T segment deviations of more than 1 mm. in any lead.
3. No significant T-wave changes occurred in the standard leads.
4. In 8 tests performed on the 4 younger men, who were in good training, the T-waves in Cf_4 remained the same or gained height immediately after play. In 4 tests of the 3 older men (43, 45, 46 years), who were obviously exhausted by their efforts, the T-waves in Cf_4 lost from 1 to 3.5 mm. of amplitude. This effect was attributed to transient ischemia of the myocardium.
5. In comparing the early November and late January results for the 5 men who played at both times, no significant differences were found in their electrocardiogram patterns. The reason for this was thought to be that they played up to their full capacities on each occasion.

Thus far, I have emphasized the ways in which skiing may be expected to strain the heart. Now we come to the big question: What is the incidence of heart attacks while skiing? To obtain information on this point, I contacted a number of experienced individuals, medical and lay, and obtained practically the same answer from each: there is no incidence of cardiac episodes (acute asthma, angina pectoris, coronary occlusion, etc.) among skiers actually engaged in skiing. The doctors who wrote me to that effect were:

1. Dr. John R. Moritz, Sun Valley, Idaho. He stated, "We have never recognized a case of coronary insufficiency among skiers."
2. Dr. Robert C. Lewis, Jr., Aspen, Colorado. "I . . . cannot recall a single case of . . . any kind of cardiac emergency which could be said definitely to have been the result of skiing."
3. Dr. Arthur Perkins, Ogden, Utah. "There has never been a case of cardiac difficulty on the part of skiers in Snow Basin . . . nor do I find any record of such difficulty throughout the country during the years that I served as chairman of the Medical Committee of the National Ski Patrol System, 1946–49."

4. Dr. Irvin E. Hendryson, Denver, Colorado, the present chairman of the N.S.P.S. Medical Committee. "I have been unable to find any recorded instances of heart attack . . . in any of the reported skiing accidents for the year 1951." The same applied to his survey of the reports of the Southern Rocky Mountain Ski Area for the past ten years.

The responses from laymen were as follows:

1. Mr. Charles Roos, Armed Forces Medical Library, Washington, D. C. " I have not been able to locate material relating to cardiac strain in ski troops of the United States or other armies."

2. Mr. Fred Pabst, Jr., Big Bromley, Manchester, Vt. "We have never had any accidents such as this."

3. Mr. J. M. Muiry, Superintendent, Whiteface Mountain Authority, Wilmington, N. Y. "According to our records . . . since 1948, I can find no instance or report indicating a skier has ever suffered a heart attack as the result of skiing on our slopes or trails."

4. Mr. P. A. Robertson, Manager, Cranmore Skimobiles, North Conway, N. H. "We have never . . . had a person suffer from a heart attack."

5. Mr. Roland Palmedo, Eastern Ski Area Operators Association, New York City. "I do not remember having heard of any skiers having had heart attacks, angina pectoris, acute asthma, or the like while on ski slopes."

6. Mr. Roger A. Peabody, Franconia Notch State Reservation, N. H. ". . . there have been no skiers who have been affected by heart attacks . . . while on Cannon's trails or slopes."

7. Mr. Stephen J. Bradley, Winter Park Recreational Association, Denver, Colorado. "We have had no heart attacks among skiers while actually engaged in skiing."

8. Mrs. Alfred Lindley (nee Grace Carter, member of U. S. Girls Olympic Ski Team, 1937), Minneapolis, Minn., told me she had never known of heart episodes occurring in the pursuit of skiing.

Finally, I had occasion to ask Dr. Paul D. White of Boston whether any case had come to his attention, and he was the first to reply in the affirmative. The patient was a 62-year-old physician. The circumstances were recently described to me by his son, who is a thoracic surgeon: "He had put on his skis early in the morning at the practice slope (in New England) . . . (whereupon) he experienced substernal oppression and peripheral circulatory collapse. . . An electrocardiogram the following morning was consistent with coronary occlusion." He died that night. No necropsy was performed. The doctor's skiing experience dated from the early thirties. He was "physiologically well preserved" and had had no known prodromata.

Summary

The decline in the partial pressure of atmospheric oxygen, which one encounters as he ascends to skiing terrains in the mountains, is described as an important factor causing heart strain.

The effects of violent exercise upon the electrocardiograms of 7 men of various ages and states of athletic training are presented. Evidences of heart strain were obtained in the 3 older subjects.

A survey to determine the incidence of heart attacks while skiing is described. Only one case was discovered and that appeared to have happened quite coincidentally, since the victim had just put on his skis.

Conclusions

1. Skiing, especially at altitudes above 6,000 ft., imposes a strain upon the heart.

2. The most likely explanation for the negligible incidence of heart attacks among skiers is that people with coronary insufficiency either do not ski or, if they do, they ski within their limitations.

Addendum

After presentation of the above paper, 3 members of the audience informed me of 3 more cases of fatal heart attacks associated with skiing. Postmortem proof of coronary occlusion, however, was known to have been obtained in only one of them.

425 East Wisconsin Avenue.

REFERENCES

1. Suzman, M. M., and Jokl, E.: Analysis of series of electrocardiograms taken after prolonged intense muscular activity, South African J. M. Sc. 1: 206–214 (June) 1936.
2. Jokl, E., and Melzer, L.: Acute fatal non-traumatic collapse during work and sport, South African J. M. Sc. 5: 4–14 (March) 1940.
3. Jokl, E., and Suzman, M. M.: Aortic regurgitation and mitral stenosis in marathon runner, with special reference to effects of valvular heart disease on physical efficiency, J. A. M. A. 114: 467–470 (Feb. 10) 1940.
4. Jokl E.: Cardiovascular disease and athletic efficiency, Acta med. orient. 9: 1–9 (Jan.) 1950.
5. Klemola, E.: Electrocardiographic observations on 650 Finnish athletes, Ann. med. int. Fenniae 40: 121–132, 1951.
6. Christensen, E. H., and Höberg, P.: Physiology of skiing, Arbeitsphysiologie 14: 292–303, 1950.

Development of Health Examination Programs for Employees of Wisconsin Schools

By A. A. PLEYTE, M. D., and DUANE STERNITZKY*
Milwaukee

THIS paper is the third in a series dealing with health examinations of school employees, and is prepared at the request of the Division on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin.

Many instances have occurred in Wisconsin in recent years in which school children have become infected and in due time developed tuberculosis after association with teachers or school employees who had the disease in an active stage.[1,2] This experience has been echoed in other areas.[3,4]

There is little need to labor the importance of clearing up this situation. Greater attention must be given to the paramount consideration—the health of the school child. An annual chest examination and x-ray in conjunction with a complete physical examination for all school employees will minimize the danger to children of contracting tuberculosis in the school.

Early in 1953, the Division on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin conducted a survey among Wisconsin schools to learn the status of compulsory health examination programs for school employees. The research department of the Wisconsin Anti-Tuberculosis Association assisted in the tabulation and interpretation of the questionnaires returned by the schools.

Questionnaires were sent to 588 school systems. A response was received from 456, or a 78 per cent return. The mailing included city superintendents, supervisory principals of high schools not under the jurisdiction of any city superintendent, directors of city vocational schools, county rural normal school principals, county superintendents, and presidents of state teachers colleges. In the final tabulation the latter two groups were eliminated. (Eight county systems claim a county-wide program. However, many county superintendents pointed out that although they favor a compulsory health examination for school employees, the final power to inaugurate and carry out a program is vested in the local school boards. It was also felt that experience at county or state teachers college level would not be strictly comparable with that of other schools.) Included in the study are 409 school systems.

Findings

The tendency for a progressively greater proportion of the schools to report a program as the size of the school increases may be noted. Less than one fourth of the schools with under 15 employees claim a program, while over three fourths of the schools with more than 100 employees claim a program.

The most arresting fact shown by Table 1, however, is the excellent improvement made since the beginning of 1949. The number of schools with an employee health

TABLE 1—*Wisconsin Schools with Employee Health Examinations by Time of Program Inauguration*

Number of Employees	Systems Responding	Programs in Effect at Time of Survey		Programs Inaugurated before 1949, or Date Unspecified*		Programs Inaugurated in 1949 or Later	
		Number	Per cent	Number	Per cent	Number	Per cent
TOTAL	409	159	39	72	18	87	21
1–14	110	26	24	8	7	18	16
15–49	228	89	39	34	15	55	24
50–99	44	24	55	15	34	9	20
100 and over	26	20	77	15	58	5	19
unknown	1						

*If it is assumed that all programs with inauguration date unspecified were begun prior to 1949, the percentage of schools with programs at the beginning of 1949 is 18 per cent, comparable with the 17 or 18 per cent claiming a program at the time of the Pleyte–Pommerenck survey in early 1949.[2]

*From the Wisconsin Anti-Tuberculosis Association.

TABLE 2—*Frequency of Re-examination*

Number of Employees	Programs in Effect	Annual		2 years		Other*	
		Number	Per cent	Number	Per cent	Number	Per cent
Total	159	104	65	15	9	40	25
1–14	26	20	77	1	4	5	19
15–49	89	67	75	6	7	16	18
50–99	24	11	46	4	17	9	38
100 and over	20	6	30	4	20	10	50

*Includes schools indicating re-examinations every 3 years, 5 years, and unspecified.

TABLE 3—*Programs Requiring a Chest X-ray*

Number of Employees	Programs in Effect	Programs Requiring X-ray		Programs Not Requiring X-ray		Unspecified	
		Number	Per cent	Number	Per cent	Number	Per cent]
Total	159	137	86	17	11	5	3
1–14	26	25	96	1	4		
15–49	89	74	83	10	11	5	6
50–99	24	19	79	5	21		
100 and over	20	19	95	1	5		

examination program has more than doubled. A great share of this improvement can be credited to the small school systems. School systems with under 50 employees are responsibile for 73 of the 87 "new" programs.

An effective employee health examination program must include provision for recurring examinations. An annual re-examination is generally considered most desirable. Table 2 indicates that less than two thirds of the programs provide for an annual re-examination.

The smaller schools have better programs than larger schools. Over 75 per cent of schools with under 50 employees provide for an annual re-examination; well under 50 per cent of the larger schools so provide. This may indicate that the newer programs, 84 per cent of which are in the smaller schools, are also the better programs. It may also suggest that schools that have had programs in effect for several years should re-evaluate their program requirements.

Table 3 indicates that most employee health examination programs require a chest x-ray. The greater frequency of "better" programs among the smaller schools is seen again. Only the schools with 100 and more employees are an exception in this case. Eighty-six per cent of Wisconsin school systems have included this requirement in their examination program. However, a chest x-ray should be included among the minimum requirements of any program. It is even questionable whether the 17 which claim programs but do not include a chest x-ray among their requirements should be considered as having an examination program.

Since 1947, school boards (Milwaukee County school boards excepted) have been permitted to require, as a condition of employment, periodic health examinations of all school employees, except those objecting on religious grounds. The law also states that the cost of such examinations, x-rays included, shall be paid from school district funds.

Yet, both in 1949 and in 1953, many school districts did not accept the charge. In 1949, 6.7 per cent of Wisconsin school systems accepted the cost of the examination. In 1953, only 18 per cent of the school boards, or 45 per cent of those claiming a program, accepted the charge for re-examinations. Table 4 does not indicate any substantial correlation between source of payment and size of school. The employee is the source of payment for initial examination in 47 per cent of the schools with a program; the board in 43 per cent of the schools. The number and proportion of schools paying for the re-examination is only slightly higher. The school board has accepted the charge in 70 per cent of the schools with over 100 employees, per-

TABLE 4—*Source of Payment for Examination*

Number of Employees	Programs in Effect	INITIAL EXAMINATION						RE-EXAMINATION					
		Employee		Board		Other		Employee		Board		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Total	159	74	47	69	43	16	10	26	16	72	45	61	38
1–14	26	10	38	13	50	3	12	3	12	11	42	12	46
15–49	89	46	52	34	38	9	10	18	20	36	40	35	39
50–99	24	9	38	12	50	3	13	3	13	11	46	10	42
100 and over	20	9	45	10	50	1	5	2	10	14	70	4	20

haps indicating that large groups of employees are more influential in persuading the board to accept the charge.

Groups Examined

The survey shows that most schools (146) out of those claiming a program include teachers among those examined. Some examine only teachers, only bus drivers, or only food handlers. Some schools, especially vocational schools, state that part-time employees are not examined. Any effective program must include all employees in contact with students.

Examining Group

Most school systems (104) out of those with a program allow the employee to select the physician of his own choice. Only 12 schools utilize a panel of physicians for the examination; 7 of these 12 are schools with 50 or more employees. Twenty-two systems designate the physician who is to conduct the examination.

Determination of Fee

The examining physician in 81 school systems determines the fee to be charged. In 26 schools, the school board sets the amount; in 16 schools, the county medical society determines the fee.

The questionnaire asked the school administrators to indicate the amount of fee allowed by the school board or county medical society. Only 27 schools stated the amount allowed. The median amount for this small group responding was $7.50 per examination including x-ray.

Report of Findings

The questionnaire also asked the school administrator to indicate the individual or group to whom the report of findings of the examination was made.

The largest number of school systems (74) ask that findings of the examination be reported to the school board. In 42 school systems, the findings are reported to a designated physician; the remaining schools (43) left this question unanswered.

This high proportion of unanswered responses to this question may be partially due to the position of the question near the bottom of the questionnaire. However, the lack of response suggests that in some cases, at least, there is no predetermined follow-up plan.

Summary and Conclusion

A survey of Wisconsin schools was conducted to determine the extent of school employee health examination programs.

The survey indicated that there has been a gratifying increase in the number of routine health examination programs in Wisconsin schools since early 1949, when the last survey was conducted. Extension of the program coverage among the smaller schools has been especially marked. Despite the increase, at this time the majority (or 61 per cent) of the schools which responded to the questionnaire still do not have an examination program.

Many of the examination programs lack one or more of the essentials of a "good" examination program. Less than two thirds of the school systems require an annual re-examination. Eleven per cent of schools claiming a program do not require a chest x-ray as part of the examination.

The study indicates that programs inaugurated before 1949 are "weaker" programs, and suggests that re-evaluation of older programs is needed.

Children have been offered varying degrees of protection in 159 of our school systems. More complete programs in some of these 159 schools and extension of complete programs to our remaining schools in the near future will give Wisconsin children a better opportunity to become healthy adults.

(A.A.P.) 1018 North Jefferson Street.

REFERENCES

1. Pleyte, A. A.: Physical examination of school employees with special reference to tuberculosis, Wisconsin M. J. 45:497–500 (May) 1946.
2. Pleyte, A. A., and Pommerenck, K.: Tuberculosis control programs among school personnel, Wisconsin M. J. 49:212–214 (March) 1950.
3. Horton, R., et al.: Epidemic of tuberculosis in a high school, J.A.M.A. 149: 331–334 (May 24) 1952.
4. Prevention of tuberculosis in schools (Foreign Letters, Sweden), J.A.M.A. 149:1593 (Aug. 23) 1952.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WCAN	Milwaukee	Sunday	6:15 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:45 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	5:45 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	4:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Tuesday	7:15 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:15 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:00 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

More on Abuse of Antibiotics

There was presented recently on this page of comments[1] a brief discussion of acquired resistance towards some of the antibiotics by certain infectious bacteria. Evidences of this acquired tolerance or resistance are becoming more and more common as individuals of the medical profession become more and more cognizant of such possibilities. The first large-scale awakening to this fact of acquired resistance came to the forefront soon after the widespread use of the sulfonamides. It was soon found that gonococci were rapidly acquiring a high-grade tolerance to these drugs to the extent of practically complete tolerance to therapeutically safe dosages. A curious paradox appeared: while the infective organisms became tolerant to the drug, the subjects of the infection, the patients, often became intolerant. Still farther back is the well-known "arsenic fastness," or resistance, described by Ehrlich as occurring in trypanosomes after being exposed, within the blood stream, to noncurative doses of an organic arsenical drug administered intravenously to infected animals. Organisms which reproduce in periods of minutes have a tremendous advantage in adaptation over organisms such as man, who requires a score of years, more or less, for a single generation. Infinitely small changes in a second generation bacterium, when repeated and intensified in the very few minutes required for reproduction, can conceivably add up to a very considerable change in a period of a few days or weeks. The process of "survival of the fittest" does the rest.

Needham and Nichols[2] made cultures of bacteria from the upper respiratory tract of each of a series of 100 patients who were without signs, symptoms, or complaints of upper respiratory infections. Cultures from 25 of these patients contained staphylococci in sufficient numbers as to qualify these individuals as carriers. These organisms were quite tolerant to penicillin in concentrations normally inhibitory. Forty per cent of a group of 100 healthy nurses possessed micrococci in their respiratory passages, and one half of these cultures were uninhibited by ordinarily effective concentrations of penicillin. The majority of these patients and nurses did not possess drug-resistant staphylococci prior to coming to the hospital.

Finland and Haight[3] have reported a study of 500 strains of Staphylococcus aureus with respect to sensitivity to penicillin. They insist on the development of high-grade resistance occurring within the preceding two years and also a somewhat corresponding resistance to aureomycin and oxytetracycline (Terramycin). They believe that bacteria, once having become resistant, are likely to remain so for an indefinite period even in those patients who have not received antibiotics. Cross-resistance to the various antibiotics occurs. Jackson, Vicher, and Soska,[4] in their study of hundreds of strains of staphylococci, state that the relative insusceptibility to antibiotics has significantly increased within the short period of approximately two years.

Lepper *et al.*[5] state that several hundred patients not previously treated by antibiotics in one hospital had a higher "carrier rate" at discharge than they had on admittance and that the percentage incidence of resistant bacteria in these individuals was definitely increased. They believe their evidence points to a "free interchange" of bacterial organisms between patients, as well as between patients and hospital personnel.

One can scarcely doubt that such a drug tolerance towards the newer antibiotics, as well as cross-tolerance, will rapidly increase and hence become dangerously refractory to treatment by these drugs, as has already occurred in the instance of gonococci towards the sulfonamides. All this evidence strongly points to the validity of the teachings of this writer that these drugs are to be considered as emergency therapeutic crutches to be used only in seriously threatening conditions. In these critical instances, therefore, the antibiotics should be used in large doses in order

to avoid the development, or augmentation, of drug tolerance by the bacteria.—A. L. TATUM, M.D.

REFERENCES

1. Tatum, A. L.: Acquirement of resistance to noxious agents, Wisconsin M. J. 51:699–700 (July) 1952.
2. Needham, G. M., and Nichols, D. R.: Recent changes in sensitivity of micrococcus pyogenes to various antibiotic agents, J. Lab. & Clin. Med. 41:150–156 (Jan.) 1953.
3. Finland, M., and Haight, T. H.: Antibiotic resistance of pathogenic staphylococci, A.M.A. Arch. Int. Med. 91:143–158 (Feb.) 1953.
4. Jackson, G. G., Vicher, E. E., and Soska, J. W.: Clinical observation of changes in sensitivity of bacteria to antibiotics, Am. J. Clin. Path. 23:297–302 (Mar.) 1953.
5. Lepper, M. H., Dowling, H. F., Jackson, G. G, and Hirsch, M. M.: Epidemiology of penicillin- and aureomycin-resistant staphylococci in a hospital population, A.M.A. Arch. Int. Med. 92:40–50 (July) 1953.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The 20th Annual Meeting of the American College of Chest Physicians will be held in San Francisco from June 17 through 20, 1954. Physicians interested in presenting scientific papers on any phase in the diagnosis and treatment of heart and lung disease should send a 100-word abstract, not later than Jan. 1, 1954, to Dr. Edgar Mayer, Chairman of the Committee on Scientific Program, 850 Fifth Avenue, New York 21, New York.

FALL POSTGRADUATE LECTURES AT MARQUETTE

"Therapeutics in General Medicine" is the subject of a series of postgraduate lectures to be given on five Thursday mornings in October and November from 10:30 a. m. to noon. Lecture dates are October 22 and 29 and November 5, 12, and 19.

Directed by two faculty members of the Marquette University School of Medicine, Francis D. Murphy, M. D., professor of medicine, and Harry Beckman, M. D., professor of pharmacology, the series has a tuition fee of $25.00. Application should be made to the Director of Postgraduate Programs, 561 North 15th Street, Milwaukee 6, Wisconsin.

ANNUAL DEARHOLT DAYS TO BE HELD NOVEMBER 9 AND 10

Principal speakers for the annual Dearholt Days to be held this year on Monday, November 9, in Milwaukee and Tuesday, November 10, in Madison are William B. Tucker, M. D., chief of the tuberculosis service at the Veterans Administration Hospital in Minneapolis and clinical assistant professor of medicine at the University of Minnesota; and William H. Feldman, D. Sc., experimental pathologist at the Mayo Clinic.

Doctor Tucker will speak on "The Accurate Evaluation of Therapeutic Procedures in Clinical Medicine: Cooperative Studies in the Chemotherapy of Tuberculosis." Doctor Feldman's subject is "Anti-tuberculosis Properties of Substances Considered for Therapeusis: Their Detection and Experimental Evaluation."

The speeches will be given at the Marquette University School of Medicine on Monday at 3:00 p. m. and again on Tuesday at 3:00 p. m. at the University of Wisconsin Medical School. On Tuesday evening at 8:00 p. m. Drs. Tucker and Feldman will speak at a meeting of the Dane County Medical Society at the Veterans Administration Hospital in Madison.

Dearholt Days are held yearly in memory of the late Hoyt E. Dearholt, M. D., first executive secretary of the Wisconsin Anti-Tuberculosis Association and a leader in the control of tuberculosis in Wisconsin. All interested physicians are invited to attend.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

Present Illness

Dr. Reuben Beezy (Resident in Internal Medicine): This 59-year-old colored male entered the hospital on Jan. 23, 1952. At the time of admission the patient was not oriented as to time or place and was unable to give an accurate history. He did state, however, that he had been coughing for about a week, that he hurt all over, and that he could not swallow and felt weak.

Past History

We were not able to obtain a past history from the patient. However, the review of his clinical records revealed that he first entered this hospital in November 1938 because of dizziness and vomiting on awakening from sleep. The vomiting would recur when he lay on his left side or on his back. He also complained of a hissing noise in his left ear of one year's duration. In November 1940 the patient re-entered the hospital because of a purulent discharge from the left ear of nine months' duration. In October 1942 the patient re-entered the hospital because of hemorrhage of the left ear. A radical mastoidectomy was done at that time. He was again admitted in May 1944 because of blurred vision. In July 1945 the patient was admitted because of paralysis of the left palpebral muscle with exposure of cornea of two weeks' duration. He was re-admitted in May 1947 because of the left facial paralysis of one year's duration. In March 1950 the patient was again admitted because of bleeding from the left ear of one year's duration. A revision of the mastoidectomy was performed at that time. The patient subsequently entered this hospital on three occasions because of fractures caused by falling.

Physical Examination

At the time of admission, physical examination revealed an emaciated colored male who appeared acutely ill, had audible rales in his trachea, and was not oriented as to time or place. Examination of the head and neck revealed left facial paralysis. He could not close his left eye. His left forehead was smooth. A mastoidectomy scar was present on the left. The ear drums were opaque. The pupils reacted to light. The left pupil was smaller than the right pupil. Extra-ocular movements were not evaluated. Examination of the mouth revealed the tongue and pharynx to be dehydrated. The patient could not cooperate to determine whether the tongue deviated. Examination of the neck revealed some nuchal rigidity. The chest was symmetrical. Expansion was bilaterally limited. Examination of the lungs revealed moist rales in the left base with inspiratory and expiratory rales and rhonchi in the right anterior and right posterior chest wall. The cardiovascular system was essentially normal. Blood pressure was 92/60. Examination of the abdomen revealed no significant findings. Genitalia were normal. Sphincter tone was poor. The prostate was small and non-tender. The feces were black. Examination of the extremities revealed two scars on the left forearm. There was generalized emaciation. Neurological examination revealed the right pupil to be dilated. Reflexes were more marked on the left. Hoffmann's sign was negative, and there was a bilateral Babinski, more marked on the left. There was also an unsustained clonus on the left. There was paresis on the left side.

Laboratory Examinations

A blood culture, done on Jan. 24, 1952, was positive for pneumococci. Urinalysis was essentially negative. The white blood cell count on admission was 8,600 with 93 per cent neutrophils and 7 per cent lymphocytes. The red blood cell count was 3,900,000, hemoglobin was 8 Gm., and Westergren sedimentation rate was 160 mm. per hour. Serology was negative. Blood chemistry was normal. Tuberculin test was 1 plus. Sputums were negative for acid-fast bacilli. Spinal fluid examination was within normal limits. Chest x-ray on January 23 revealed confluent

From the Departments of Pathology, Veterans Administration Hospital, Wood and Marquette University School of Medicine.

pneumonia in the right lower lung field. A bedside chest x-ray taken on January 28 revealed some resolution of the previously demonstrated pneumonia of the right lung. There was no demonstrable pleural effusion.

Clinical Course

The patient was febrile on admission and remained febrile throughout his hospital stay. He was unable to take any food by mouth and had to be fed intravenously. He required a tracheal toilet by the anesthesia department. On admission he was treated initially with 200,000 units of penicillin every three hours for his pneumonia. Because of his low blood count, the patient was given one blood transfusion. The following day the patient seemed more alert and was somewhat oriented. His main complaint at that time was difficulty in swallowing. Within 48 hours the patient was again semicomatose. Physical findings were always demonstrated on chest examination. On January 31 the patient attempted to take oral fluid and was able to answer simple questions. Shortly afterward, however, he lapsed into coma. He died on February 2.

Dr. Robert G. Zach (Resident in Radiology): The last chest x-ray showed the pneumonia in the right base. There was some enlargement of the heart, mainly of the left ventricular bases. We have several series of skull films. The films from 1950 show the results of a simple mastoidectomy with some residual mastoid cells still present on the left. In the region of the petrous pyramid we see the area of decreased density. There is probably some erosion of the bone. (Fig. 1) We could not determine whether this was due to extension from the ear or some other cause. The lateral views of the mastoid show the same findings. In the posterior border of the external auditory canal there is somewhat decreased density, and the possibility of erosion could not have been excluded at that time. In 1951 the patient was admitted with the fracture in the region of the right zygoma. There is some increased density in the region of the right maxillary sinus, probably due to hematoma or bleeding in the soft tissues over the region.

Dr. Joseph M. Lubitz (Pathologist): Do you have any x-rays taken before the mastoidectomy?

Fig. 1—X-ray films of mastoid bones (1950). Right mastoid is normal. Left shows residuals of mastoidectomy. There is superimposed decreased density of petrous pyramid and erosion of auditory canal owing to tumor invasion.

Doctor Zach: Yes, they were essentially negative.

Dr. John L. Garvey (Neuropsychiatrist): We note that the patient had many hospital visits, the first one dating back to 1938 when he came in because of dizziness and vomiting on awakening from sleep. This symptom in itself could be the result of any number of derangements. But if you will note when he was admitted a second time, in 1940, he had a purulent discharge from the left ear of nine months' duration. His third admission was two years later, in 1942, again because of hemorrhage of the left ear. At that time, obviously, it was presumed that he had an inflammatory lesion of the left temporal bone. No mention is made up to this point, or at any time, about difficulty with hearing. The patient was again admitted for blurring of vision, which was obviously not a local temporal bone symptom, but subsequently he had weakness, apparently not complete, of the left side of his face. On his fifth admission, however, it is noted that he had paralysis of the entire left side of the face. In March 1950 he had his sixth hospital admission because of bleeding from the left ear of one year's duration. At that time a second operation was performed on his mastoid, presumably because of inflammatory lesion of the temporal bone and with the results of the first mastoid operation at hand.

Now we take the story up to that point. It sounds very much as though his entire picture was the result of something that had started in the mastoid or in the temporal bone on the left. Inflammatory lesion? Yes. Two operations were performed for inflammatory lesion of the mastoid area. However, other things must be considered. One must consider the possibility that he may have had some secondary infection of the destroyed bone in that area, secondary to some other lesion, and conceivably a tumor of the eighth nerve, but nothing is mentioned at any time about his hearing. In tumors of the eighth nerve there can be considerable destruction of the temporal bone. Usually the first symptom, before the development of facial palsy or the involvement of the fifth nerve with pain, is marked difficulty with hearing. Another point in favor of the possibility of a neoplasm in that area is the fact that the patient's symptoms continued over a long period of time in spite of two operations. One cannot tell from this protocol why he fell—whether he was continuing to have considerable vertigo which caused these various falls.

Apparently the facial palsy continued, for on his admission in January of this year he had an easily recognized left facial paralysis, the same side as the disease of the temporal bone for which he had been treated previously. If we note the other neurological findings at the time of his last admission in January, we find that he had a left hemiplegia. I presume that the inference is that the patient's facial palsy on the left side was a peripheral type of facial palsy. Apparently the assumption is that the left side of the body, the same side as the peripheral facial palsy, was not paralyzed. This complicates it just a little bit. Also, in the condition in which he was admitted, it is a little unusual to find that he had inflammatory lesions and that his spinal fluid was entirely negative in this terminal stage. However, we also know that he had a pneumonia. Many of these neurological findings may not be the actual cause of his terminal state in January. The question has already been asked, What did his mastoid area in the temporal bone on the left look like before he was operated on? Undoubtedly x-rays were taken before. Do you have these films?

Doctor Zach: We have films taken in 1942 before the patient had been operated on. They are of the left mastoid showing numerous areas of normal cells. The auditory canal shows no abnormality. These are numerous films from 1940 to 1942, all showing nothing abnormal.

Doctor Garvey: That was in 1942, before either operation. In 1940 he had a purulent discharge from the ear. In October 1942 he entered because of hemorrhage from the left ear. Apparently the mastoid operation was done shortly after the x-ray showing no enlargement or atrophy of the bone in the region of the internal auditory canal was taken. At the time of his last admission to the hospital, we note that he had bilateral cerebral signs, bilateral Babinski. Now it is disturbing, on the basis of a left-sided lesion, that he should have had a left-sided hemiplegia at this stage. There is one possible explanation: in the event that he had an expanding lesion, the brain stem might have been pressed against the opposite side of the foramen magnum and might have given left-sided signs. However, it is not common to have such a condition described as a left hemiplegia. I

would say that the patient had probably carried for a long time an intracranial infection, a localized lesion, probably an abscess, and that it caused very few actual intracranial complications or disability until it was activated. The other possibility is that he had a left acoustic neurinoma. It is interesting that the spinal fluid was entirely negative. In this stage, if this had been an abscess, I would have been suspicious that he had a rupture of the abscess in the ventricular system and that some increase in cells would have been noted. It is conceivable, however, that the number of cells *did* increase, but none reached the subarachnoid space in the lumbar area.

Dr. Thomas Morrison (Resident in Internal Medicine): Doctor Garvey, from the protocol can you localize what part of the brain or brain stem was involved?

Doctor Garvey: No, except that the patient probably had a unilateral primary lesion because of his abscess.

Doctor Lubitz: The case will be discussed by Doctor Eby from the standpoint of the ENT Service.

Dr. Lee G. Eby (Otolaryngologist): If we take the entire story in sequence, beginning in 1938, it should be less confusing. At the onset, when the patient had just the purulent draining from the ear and no record of the degree of hearing loss, his condition would certainly suggest an infection of the mastoid process. The x-rays that we had were not, however, consistent with mastoiditis, for they showed little breakdown of the cell structure of the mastoid. There is no mention of the degree of hearing loss, which would be extremely important in the case of a pure conductive hearing loss, since it would be significant of an ear infection. If, however, there were considerable perceptive elements in addition, it would suggest that the nerve fibers were involved. The slow progression of the lesion over a period of 15 years, however, suggests that the patient might have had a tumor. If the lesion had been of an infectious type, I think that the course would have been somewhat more rapid. It suggests a tumor originating within the temporal bone, because the first symptoms, before other neurologic findings, were hearing loss and tinnitus. These symptoms were followed by ear drainage, which may have been caused by secondary infection even if the lesion was a tumor. I think that hemorrhage from the ear is of some significance. With an ordinary infection you do not find hemorrhage. You may have some bleeding on manipulation, but the word *hemorrhage* suggests rather severe bleeding. To me, that suggests a vascular type of tumor. The most common tumor originating within the temporal bone is the acoustic neurinoma, originating in the sheath of the eighth nerve, usually on the vestibular portion first within the temporal bone. From there it extends outward into the cerebellopontine angle. This is not usually considered a very vascular type of tumor. More recently described, however, is a very vascular tumor originating in the temporal bone. The first description of this tumor was in 1945. It originates from the jugular bulb. The tumor then quickly extends into the floor of the middle ear cavity because of its proximity to it. Frequently the tumor is confused with infectious granulation tissue, which is associated with mastoiditis or middle ear infection. In the past this type of tumor has either been called something besides a tumor or has been diagnosed as a different type of tumor. The fact that the patient had a hemorrhage suggests this glomus, carotid-body type of tumor. From this point I think that the neurologic findings suggest extension of the tumor outward from the mastoid cavity into the cerebellopontine angle. I think it would be of considerable help to us if we knew what the caloric tests showed. These findings are of extreme significance in acoustic neurinomas, in which there is almost always a hypoactivity of the labyrinth on the side of involvement of the eighth nerve. There is no mention of that in the protocol. The fact that there is erosion of the petrous tip on the subsequent x-rays again suggests some involvement by extension of the tumor mass rather than infection, although you may get necrosis of the petrous tip as a result of petrositis. The extension then into the posterior fossa is an involvement of the area of the jugular foramen, a condition which is not so common after petrositis. The third and sixth nerves are more likely to be involved in Dorello's canal at the tip of the petrous than to be further extended into the posterior fossa. I would think that because of the hemorrhage this is very likely to be a nonchromaffin paraganglioma or a so-called tympanic type of tumor similar to the carotid-body type of tumor.

Dr. Donald A. Franklin (Resident in Internal Medicine): The possibility of intra-abdominal pathology should be mentioned, with 8 Gm. of hemoglobin and black stools. I do not know whether the stools were tested for occult blood. There is a possibility of metastatic abdominal tumor.

Doctor Garvey: Doctor Eby mentioned a non-chromaffin paraganglioma. I think that this is extremely interesting and very pertinent in this particular case. It is interesting that these tumors of the glomus jugulare have only recently attracted any attention. The first case, I think, was published in 1945, and there have been quite a few appearing in the literature at a rather rapid speed. We had just such a case at Columbia Hospital about a year ago. A young boy about 16 years old who came to us with a history of deafness for as long as he could remember had a facial palsy that had developed overnight. The referring physician sent him down to me and called my attention to the fact that he had a bad-looking eardrum and that no one should disturb it, because he thought there was a lot of blood and possibly a large vessel behind the eardrum. We did not take his advice, however; one of my colleagues did open up the eardrum and spent the rest of the afternoon stopping the bleeding. That's very characteristic of these non-chromaffin paragangliomas. Nevertheless, I think that the percentage of possibilities is strongly in favor of an inflamed mastoid bone with extension intracranially with a long period of walling off and exacerbation of the abscess. Now, that is purely from the teaching standpoint. I think the facts are true in the protocol that it probably only represents error in interpretation of the underlying pathology found at the time of operation.

Dr. Ruth Rhines (Resident in Internal Medicine): Is it possible that in addition to the left ear pathology there could be also something like a subdural hematoma on the right caused by one of the numerous falls?

Doctor Garvey: That's a very good point. It is conceivable, but I do not know that we have any positive evidence that might refer to the whole condition on one diagnosis.

Fig. 2—Gross brain and tumor. The tumor occupies the general region of the pontine angle, but actually originates from the middle ear.

Fig. 3—Gross section of tumor. The tumor is firm and fibrous with hemorrhagic foci.

Doctor Zach: I would like to ask Doctor Eby if, after all these operations and subsequent healings, this could be a cholesteatoma.

Doctor Eby: A cholesteatoma could present this picture. Neurologic involvement would then be on an infectious basis with erosion through the temporal bone.

Clinical Diagnoses Offered. (1) Acoustic neurinoma (2) Brain abscess (3) Glomus jugulare tumor.

Doctor Lubitz: The autopsy examination showed a well-developed but emaciated colored man. The residuals of the various fractures of the left wrist and left femur were noted. The mastoidectomy scar on the left was also observed. Even at autopsy the left pupil was smaller than the right. In the thorax the right lung was free, and the left lung had pleural thickening and fibrosis. There was 200 cc. of clear fluid in the left pleural cavity. The trachea and main bronchi showed a mucopurulent exudate. Both lungs were heavy, the right lung weighing 1,340 Gm. and the left lung 1,090. This was due primarily to a pneumonic process which involved the entire lung. Not only were the lungs firmer and heavier, but they also showed areas of purulent exudate indicating that the pus was coming from the bronchi, producing a confluent generalized bronchopneumonia.

The heart showed nothing significant. It was somewhat dilated. The right ventricle was slightly hypertrophied, measuring 6 mm. in thickness. The myocardium grossly showed nothing abnormal, but microscopically it showed some small scars. The liver, spleen, and kidneys showed nothing unusual. The thyroid gland was slightly enlarged and contained one nodule. The brain itself was not heavy. It weighed 1,290 Gm. There was a mass in the general region of the left pontine angle measuring 4½ by 3½ by 2½ cm. (Fig. 2) This tumor emanated from the middle ear region. It had eroded a portion of the petrous bone and the middle ear. It was closely connected to the meninges. On section it was firm and a light grayish-yellow color. (Fig. 3) Red areas were present, indicating increased vascularity. The seventh and eighth nerves could not be identified. They were completely encroached upon by tumor. The sixth, ninth, tenth, eleventh, and twelfth nerves were compressed by this tumor.

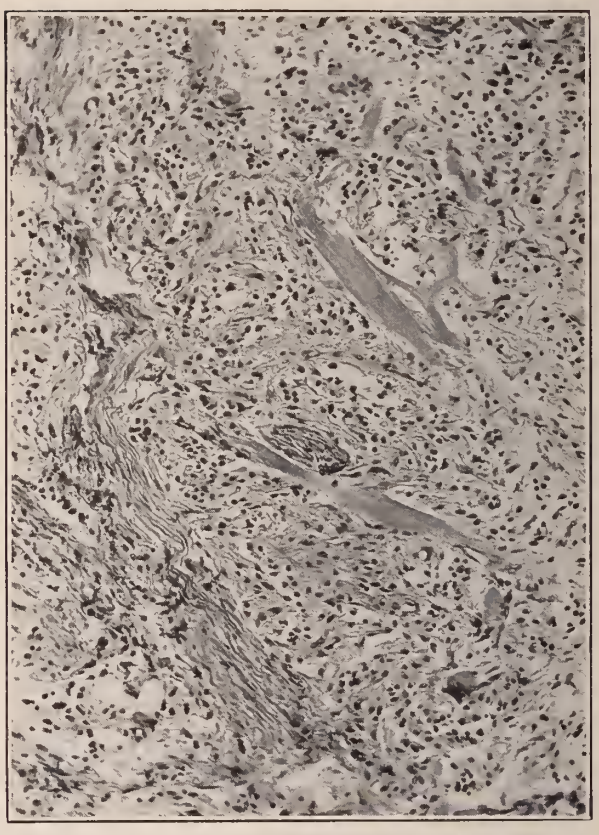


Fig. 4—Photomicrograph of tumor (125X). Vascular spaces are separated by fibrous tissue.

At this point the question as to the type of tumor was raised. An acoustic neurinoma was considered. The fact that the internal canal had not been primarily involved and the other facts that were brought out from the history lead us to believe that this was not a pontine angle tumor. The other possibility was a meningioma. A meningioma is also a fibrous tumor. It may be fibrous and vascular, and at times it does erode into the bone. Now, as we see the x-rays and the whole story, we realize that the origin was in the middle ear and involved the brain only secondarily. Now let us consider the tumor microscopically. We find small cells which are fairly uniform in size. In characteristic areas these cells form groups which superficially resemble capillaries. A dense fibrous stroma separates these cells. In some cases the tumor is exceedingly vascular. (Figs. 4 and 5) Part of the tumor shows some calcium or bone spicules. We wondered whether this tumor was producing bone, but since part of the petrous bone was involved by the tumor, it was more likely that the fragments of bone were actually due to erosion of bone and were

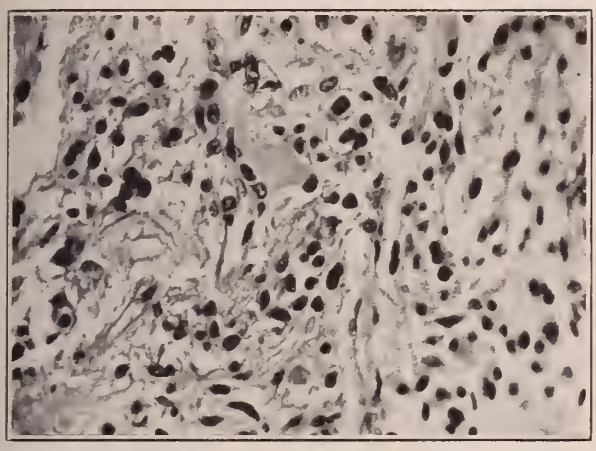


Fig. 5—Photomicrograph of tumor (225X). Vascular spaces are lined with endothelial-like cells. The stroma contains fibrous tissue.

not neoplastic. At this point we had no definite diagnosis. I am indebted to Dr. O. E. Ogilvie, who did the autopsy and came to the conclusion after study of the sections and the literature that this case was a non-chromaffin paraganglioma of the glomus jugulare. This is a tumor which, as has been mentioned, has only recently been described.

A word about the origin of these tumors. In 1941 the presence of a glomus element was described in the middle ear, either in the adventitia of the jugular vein or in the vicinity of the tympanic nerve. Actually, other foci have been identified by later workers. These ganglia resemble the structures of the carotid body. Unlike the adrenal gland, which is chromaffin, the paraganglioma is non-chromaffin. The ganglia do not take any of the chromate stains. Their function is obscure. They are vascular, and the cells that we see represent components of these blood vessels. They look as though they are the endothelial cells. Fibrosis and hemorrhage may occur. In reviewing the old slides from the mastoidectomy, I find that this vascular tissue that we called granulation tissue actually included the tumor. The superimposed inflammation gave the impression of a granuloma pyogenicum rather than of a vascular tumor. The fact that it was vascular and bled readily fits in entirely with this picture. So we came to the realization that we were dealing with a glomus jugulare tumor all these years. I would like to hear some further comment from some of the other men in the ENT Service.

Dr. Charles J. Finn (Otolaryngologist): At the time of the revision mastoidectomy performed in 1950, the type of tissue removed, or rather the presenting picture in the left ear at that time, was a smooth, readily bleeding mass. We felt it was compatible with granulation tissue. Consequently this operation was performed as a revision type of mastoidectomy. During the operation, there was considerable bleeding, and the complete removal of this tumor was not accomplished because of the difficulty in controlling hemorrhage. Nor could the depth of the mastoid cavity be explored. Perhaps if the bleeding could have been controlled, we would have followed it to a depth suggesting a tumor or intracranial extension at that time. The past history was difficult to evaluate in this patient. Before the first surgery in 1942, the records were not too complete. This patient had a tumor. We suspected granulation tissue rather than this highly vascular tumor that was proved at autopsy.

Doctor Lubitz: In conclusion I might add that this type of tumor is usually considered benign. Out of the approximately 50 cases that have been reported up to 1949, however, two have metastasized.

MIDWEST REGIONAL MEETING OF ACP TO BE HELD IN MILWAUKEE

The Midwest Regional Meeting of the American College of Physicians will be held at the Hotel Schroeder in Milwaukee on November 21, 1953. A scientific program of 22 papers, each 15 minutes long, and a clinicopathologic conference have been arranged.

Included on the day's schedule are a luncheon at noon and a banquet and entertainment in the evening. A special luncheon for wives of physicians attending the meeting has been planned.

A cordial invitation is extended to all physicians, both members of the American College of Physicians and non-members. There is no registration fee.

For further information, write Joseph W. Rastetter, M. D., Chairman of Arrangements, Department of Medicine, Marquette University School of Medicine, Milwaukee 13, Wisconsin.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Chest X-Raying of General Hospital Admissions

As It Looks to Your State Board of Health

WE BELIEVE that x-raying of persons admitted to general hospitals can be one of the most important contributions to tuberculosis control in Wisconsin. Results show that routine chest x-ray screening of hospital admissions finds at least twice as many cases of active tuberculosis as does screening of the general population. The patient, the staff, and the community benefit from the program.

The idea of giving a chest x-ray routinely to all admissions to general hospitals is not new in Wisconsin. In 1936 the Wisconsin General Hospital made a report on such a program, which was at that time somewhat of a pilot study. In 1949, a report compiled by the State Board of Health listed 57 general hospitals attempting to some extent a program of inpatient admission x-rays. This represented approximately one third of the total number of hospitals. Of the eight hospitals in this group with 250 beds or over, four reported active programs. Several hospitals reported x-raying 90 per cent of admissions; other hospitals reported a very small portion of admissions x-rayed; the majority however, were x-raying 50 per cent or more of the total admissions.

In 1952 the W.A.T.A. sent a questionnaire to all general hospitals in Wisconsin. Of the 110 hospitals responding, 22 had an active program of chest x-raying of admissions and 13 others planned to institute such a program soon. This can be interpreted roughly to mean that one fourth to one third of all general hospitals are maintaining or will maintain such a program.

The average daily census for general hospitals in Wisconsin is 10,000 individuals. It is estimated that one person in every seven in Wisconsin enters a general hospital annually. Among female admissions 40 or 50 per cent are in the childbearing age groups —15 through 34 years of age. Among male patients more than 50 per cent are 45 years of age or older. In connection with this, it is interesting to note that 57 per cent of the active and presumably active cases of tuberculosis reported in Wisconsin in 1952 fell in these two groups. Therefore, the opportunities for tuberculosis case-finding in these groups should be kept in mind.

For the past seven or eight years the State Board of Health has been encouraging the program of chest x-ray on routine admissions in general hospitals and giving support to the program by lending x-ray equipment to the hospitals for that purpose. Of course the results and benefits of such a program depend entirely upon the individual hospital and its local administration: how much use is made of the equipment; what proportion of total admissions are x-rayed; whether all prenatal patients are x-rayed, preferably early in pregnancy; whether accurate records are kept of all x-rays; and whether a follow-up program is provided for the referrals of these x-rays to determine definite diagnosis. The purpose and intention of the State Board of Health in placing x-ray equipment in general hospitals was to demonstrate the great need of tuberculosis case-finding among routine hospital admissions and to stimulate the hospitals to obtain equipment of their own to carry on such a program permanently.

Experience of the past 10 to 15 years has taught us much. We believe that one of Wisconsin's unmet needs is an adequate and active case-finding program among individuals seeking medical care for reasons other than tuberculosis. The facts call attention to the need to emphasize and to expand this type of program. An adequate hospital x-ray program should include:

(1) Thorough education of the community about the value of routine chest x-rays for general hospital admissions and thorough understanding by the medical staff and the general public.

(2) Provision for the program to be extended into small hospitals with capacity of less than 100 beds, or perhaps 3,000 annual admissions.

(3) Expansion of similar program to outpatient services.

(4) Extension of such a program to group clinics.

(5) Adoption of the policy of routine chest x-raying for private practice.—MRS. AGNES G. JENSEN, *Public Health Nursing Consultant in Tuberculosis.*

COMMITTEE *Concentrates*

DIVISION ON MATERNAL AND CHILD WELFARE AUGUST 20

MDs present: R. F. Purtell (chairman), Amy L. Hunter, G. S. Kilkenny, A. H. Stahmer, J. D. Wilkinson, T. V. Geppert, F. G. Johnson, D. D. Willson, E. A. Birge, Kenneth Winter, H. K. Tenney III.

Report of the Division to the House of Delegates was reviewed and corrected. Major attention was directed to projection of series of pilot studies into fetal and neonatal deaths, through hospital staff cooperation. The form for this study was reviewed, and procedures were set up so that the study can be launched on January 1, 1954. The Division heard a representative from the Division for Children and Youth of the Department of Public Welfare outline the many medical problems confronting that state department and the need for medical guidance. The Division agreed to serve in that capacity, and a future meeting on specific medical problems of the Division for Children and Youth will be arranged . . . . Attention was directed to special problems on prematurity, and the desirability of having a series of small instructional meetings for doctors and nurses especially interested in this type of care in Wisconsin hospitals. Tentative plans were made to develop this project during the ensuing year. . . . The Division members felt that more needs to be known about maternal deaths associated with anesthesia, and it was recommended that the Wisconsin Society of Anesthesiologists and the State Society of Nurse Anesthetists be approached concerning a joint study with the Division on Maternal and Child Welfare to secure factual information on this subject through a special questionnaire directed to Wisconsin hospital medical staffs.

COMMITTEE ON CIVIL DEFENSE SEPTEMBER 9

MDs present: M. J. Musser (chairman), K. E. Lemmer, J. S. Wier.

The Committee reviewed the status of civil defense preparations in Wisconsin and was pleased to find that unusual progress has been made during the past year in stockpiling the essential supplies that will be needed by physicians in the event of a major disaster. These supplies are stored at Camp Williams. Consideration was given to recommendations that will be made to the State Civil Defense Director concerning methods of maintaining 100 mobile medical teams in a state of readiness over a period of years.

COMMISSION ON PREPAID PLANS SEPTEMBER 13

MDs present: E. M. Dessloch, Robert Krohn, N. A. Hill, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, Richard Foregger, G. W. Carlson.

Reviewed annual report to House of Delegates and received supplementary statistical data . . . Considered problems in connection with enrollment of groups with national affiliations and requested staff study . . . Reviewed and authorized completion of a proposed catastrophic illness contract incorporating the principle of paying reasonable physicians' charges, with co-insurance on other benefits; a deductible feature will be included . . . Staff report on status of renegotiation of agency contract with Blue Cross . . . Referred to committee development of a patient-physician-public educational program.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Questions and Answers

Where can a physician obtain information about Blue Shield and Blue Cross to give to his patients?

Pamphlet dispensers may be obtained upon request to the Wisconsin Physicians Service office, Box 1109, Madison. Bulk pamph'ets may be obtained from the same address. Simply address a post card stating the quantity desired. Full descriptive literature for either group or non-group prospects will be sent to any person who requests it.

What is the difference between Blue Shield and Blue Cross?

Blue Shield is a prepayment program operated by the State Medical Society to provide benefits for services rendered by physicians. Blue Cross is a prepayment program sponsored by the hospitals to provide benefits for hospital room and board and other services rendered in a hospital by hospital employees.

How may a physician become a "participating physician" in Blue Shield?

A physician may become a participating physician in Wisconsin Physicians Service by completing an application form which is available from the State Medical Society. Every new member of the State Medical Society is sent this form as soon as his membership has been accepted. Physicians who have not taken advantage of the opportunity to become participating physicians in Wisconsin Physicians Service are contacted in July of each year. However, a physician may upon his own request become a participating physician at any time.

What is a participating physician?

A participating physician is a licensed physician and surgeon who has agreed with Wisconsin Physicians Service to accept the "full payment" provisions of the WPS contract. Participating physicians receive direct payment from Wisconsin Physicians Service for services rendered by them to persons covered by Wisconsin Physicians Service. Because a participating physician agrees to the full-payment provisions of Wisconsin Physicians Service contracts, there may be occasional differences between the physician and the Wisconsin Physicians Service subscriber about the subscriber's income. Such disputes may be submitted to Wisconsin Physicians Service for determination. By becoming a participating physician, the doctor advises his patients of his endorsement of Blue Shield and, in effect, expresses the desirability of a patient becoming a Blue Shield subscriber.

How is the physician paid?

Blue Shield will pay the physician direct if he is a participating physician. Wisconsin Physcians Service pays directly to the subscriber only when he receives services from a non-participating physician.

What benefits are not provided by Blue Shield?

Benefits are not provided for (1) any services other than those rendered by a licensed physician and surgeon; (2) any services performed primarily for diagnostic purposes; (3) maternity services, unless the participant is covered by a family contract; (4) medicines, drugs, appliances, materials, radium, blood, laboratory tests and diagnostic aids, or supplies; (5) any condition, disease, ailment, or injury covered by a Workmen's Compensation Act, or similar legislation, regardless of whether the participant elects to claim the benefits of such act or legislation; (6) services furnished to a participant in any facility of, or otherwise provided by, the United States Veterans Administration; (7) services provided under the laws of the United States of America, or of any state or political subdivision thereof, where the participant or his property cannot be made liable for the cost thereof; (8) operations performed primarily for cosmetic or beautifying purposes; (9) injections of medications; (10) services of consultants or assistants.

THE MEDICAL FORUM

DR. H. KENT TENNEY BECOMES SOCIETY'S PRESIDENT; DR. A. J. McCAREY IS PRESIDENT-ELECT FOR 1954

PRESIDENTS OF THE STATE MEDICAL SOCIETY, present, past and future, were photographed together at the annual meet'ng in Milwaukee early this month. Left to right, Dr. H. Kent Tenney, Madison, president; Dr. Joseph C. Griffith, Milwaukee, past president; Dr. Arthur J. McCarey, Green Bay, president-elect, Milwaukee Journal photo.

Milwaukee, Oct. 5.—Dr. H. Kent Tenney, Madison, was installed as president of the State Medical Society at the opening meeting of the House of Delegates October 5. He received the gavel from Dr. Joseph C. Griffith, Milwaukee, president during 1952–53.

Dr. Tenney is a past president of the Dane County Medical Society and a former speaker of the House of Delegates.

Dr. A. J. McCarey, Green Bay, was named president-elect at the final session of the House of Delegates.

Dr. McCarey will take office in October 1954. He has been a member of the House of Delegates and councilor from the 6th district. He is a past president of the Brown-Kewaunee-Door County Society.

Other officers elected by the House of Delegates were:

Dr. L. O. Simenstad, Osceola, speaker of the house, and Dr. J. W. Fons, Milwaukee, vice-speaker;

Dr. W. D. Stovall, Madison, reelected as delegate to the American Medical Association, and Dr. G. E. Forkin, Menasha, alternate delegate.

Five councilors were elected as follows:

Dr. J. C. Fox, La Crosse, 7th district, to succeed himself;
Dr. J. M. Bell, Marinette, 8th district, to succeed himself;
Dr. R. E. Garrison, Wisconsin Rapids, to succeed Dr. E. E. Kidder, Stevens Point;
Dr. R. G. Arveson, Frederic, to succeed himself;
Dr. C. E. Zellmer, Antigo, to succeed himself.

A full report on the annual meeting has been sent to all delegates and alternate delegates to the annual meeting of the society for their use in reporting at county society meetings.

Physicians Must Teach Young MD's Art of Healing as Well as Science, Tenney Says

Milwaukee, Oct. 5.—"Whether he likes it or not, and whether he knows it or not, every physician is an educator," Dr. H. Kent Tenney told the State Medical Society's House of Delegates in his inaugural address October 5.

"Doctors are Educators"

He stated that doctors are constantly placed in the role of educators of their patients and the general public. They also are the educators of younger doctors and should strive to teach them not only the practice of medicine but also the art of medicine, which is actually the art of human relationships.

The doctor who treats the disease, not the man as a whole, is falling down on his job, according to Dr. Tenney. He said there were indications that the physician of today does not enjoy the complete confidence of his patients that his father did.

"I will not admit for one moment that the physician of today is any less worthy of confidence than his father was," Dr. Tenney declared. "But the doctor of today must compress his time schedule so that he can see more people. He can do this because many an illness will respond to one or two visits or office calls as a result of improved modern drugs and does not require the many follow-up visits that would have been necessary twenty years or so ago. In the course of this, he fails to become as well acquainted with the patient as a person."

Dr. Tenney said that it is a responsibility of the physician to supply the public at large with all the sound health information possible, so that it will not be misled by quacks and faddists. "It is not enough to tell a man that a brisk rub of the back will not cure stomach trouble, or that living on raw vegetables and sunshine will not cure a cancer. We have to make him understand *why* these practices do not make sense."

COMMITTEES OF SMS DISCHARGE PUBLIC HEALTH DUTIES

Among the busiest physicians in the society are those who are chairmen and members of the various committees which perform all sorts of important functions for the betterment of public health in Wisconsin.

These physicians give generously of their time, many of them traveling long distances to attend the necessary meetings, and often much correspondence is necessary.

They are the ones who authorize the various projects which are carried out by the State Medical Society staff. It is the function of the staff to arrange meetings, carry on correspondence, and publish requested materials. Often considerable research is necessary and numerous interviews are required in carrying out these instructions. At least one staff member is always present at any committee meeting in order to inform the members what has been accomplished since their last meeting, and receive directions for future projects.

Responsible for WPS

One of the largest of these bodies is the Commission on Prepaid Plans, which is headed by Dr. E. M. Dessloch, Prairie du Chien, and has sixteen members. It is the duty of this committee to supervise the two prepaid plans under the jurisdiction of the society—Blue Shield and the Wisconsin Plan.

To them must be brought all proposals for new developments in these plans. Newer and better coverage is discussed. Administrative revisions necessitated by the new programs must be approved. It is constantly faced with the necessity of classifying new medical procedures which are developed by advances in the science of medicine, and assigning proper benefits to them.

Under their leadership, all contracts have been converted to a more complete type of coverage during the past year, and many manual procedures in the handling of claims have been replaced by IBM equipment recently installed in the society offices. Office personnel necessary for handling the volume of insurance business is constantly increasing in number.

A new group this year is the Commission on State Departments which replaced a number of special advisory groups to various departments of the state government. These advisory functions are expected of medical men, and the call must be met by supplying physicians possessed of the necessary knowledge in certain fields together with an interest in the public health problem involved.

What does the State Medical Society do for its members? This is the second of a series of articles which explains the services of the society to the physicians who belong to it.

This commission, which is headed by Dr. T. W. Tormey, Jr., Madison, consists of nine members, each of whom heads a sub-committee connected with a particular public health problem. There are divisions on crippled children, geriatrics, maternal and child welfare, nervous and mental diseases, public assistance, rehabilitation, school health, tuberculosis and chest diseases, and visual and hearing defects.

Each of these divisions has its own meetings, plans its own projects, and deals with the particular problems arising out of its advisory capacity to certain departments. The meetings of the commission as a whole enable the division chairmen to check with each other so that conflicting advice is not given to two departments whose functions may, in many cases, overlap.

Three Sub-Committees Work

The division on nervous and mental diseases has three sub-committees operating at the present time. One division is studying the laws relating to the commitment of mental patients to institutions. Another is outlining a course of training for residencies in psychiatry. The third is studying the problems of the emotionally disturbed child.

Dr. W. D. Stovall, Madison, is chairman of the Committee on Blood Banks, which serves in an advisory capacity to the Badger Blood Center and is available to the Junior League Blood Center in Milwaukee. It also offers assistance to smaller local blood banks connected with hospitals. It has had the problem of assisting the State Health Officer to establish basic policies for the distribution of gamma globulin for control of poliomyelitis. It handles any complaints about blood programs which are presented by either a physician or a hospital.

The Veterans Medical Service Agency of the State Medical Society operates the program known as the home-town care program for veterans in cooperation with the Veterans Administration. Dr. J. S. Supernaw, Madison, is chairman of the operating committee in charge of this service. All claims are paid from the medical society office with three staff members spending their entire time at this work. The operating committee occasionally meets with doctors from the Veterans Administration for discussion of problem cases and exchange of information.

Help Cancer Society

The Standing Committee on Canced, headed by Dr. R. P. Welbourne, Watertown, functions primarily as the medical and scientific committee of the Wisconsin Division of the American Cancer Society. It assists with the development of projects in professional education and the training of technicians in exfoliative cytology, and has reviewed and recommended financial support for specific research projects at McArdle Institute, the cancer study portion of the University Hospitals.

The committee on grievances listens to any complaints of neglect, malpractice or general dissatisfaction expressed by patients against the medical profession and adjusts and mediates such affairs as best it can. Dr. R. E. Fitzgerald, Milwaukee, is chairman.

The Committee on Hospital Relations, headed by Dr. A. H. Barr, Port Washington, stands ready to settle any disputes between hospitals and physicians in the fields of pathology, radiology or anesthesiology.

The Committee on Medical Education and Hospitals is concerning itself with gathering data which would be of importance to hospitals on all physicians, and reducing it to a form that might be set up on a punch-card system for rapid and efficient classification. It is preparing to conduct pilot studies on the distribution of medical care in several localities, and concerns itself with the matter of physician placement. It is studying the pre-

WISCONSIN HEALTH CONFERENCE SET FOR NOVEMBER 4 AND 5 IN MADISON

Madison, October 10.—The Wisconsin Health Conference, sponsored jointly by the State Medical Society and the Wisconsin Public Health Council, will take place in Madison November 4 and 5 at the Memorial Union.

Geared to discussion of rural health problems and community organization for health, the conference is replete with speakers of national and state-wide repute.

Dr. Walter C. Alvarez, Chicago, consultant in medicine emeritus of the Mayo Clinic, will be one of the main speakers, as will Dr. F. S. Crockett, Lafayette, Ind., chairman of the AMA council on rural health. Dr. John S. DeTar, Milan, Mich., former president of the Michigan Health Council, will also be a speaker.

A forum on cancer is planned for the evening of November 4. Dr. W. D. Stovall, Madison, and Dr. W. S. Bump, Rhinelander, will team up with Dr. Stanley P. Reimann, Philadelphia, and Dr. H. W. Meyer, New York, to answer questions submitted by interested persons.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the society's commission on prepaid plans, and Prof. Charles C. Center of the University of Wisconsin's department of commerce will give a joint report on the present status of prepaid health insurance in Wisconsin.

Orlo Miller, Madison, coordinator of school health with the State Department of Public Instruction, will be moderator of a panel which will discuss conditions in our unsanitary rural schools and what can be done to correct them.

A layman's viewpoint will be expressed by Gordon Crump, editor of the Cambridge *News*, who will explain why he feels his community needs an active health council; and people from several communities will tell of the organization of successful health projects "back home." Citations are to be presented to the person and to the group which have done the most to further health in their communities during the past year.

ceptorship system in medical education. Dr. T. L. Squier, Milwaukee, is in charge.

The Council on Medical Service, of which Dr. D. E. Dorchester, Sturgeon Bay, is chairman, has been primarily concerned with the extension of its public relations and health information activities into specific "problem" areas. Its work has been directed toward health council development, emergency medical services, nursing education, audio-visual aids in health education, and rural and industrial health. It has directed the production of pamphlets and publications along these lines.

The Committee on Public Policy, headed by Dr. J. M. Sullivan, Milwaukee, is responsible for the legislation which the State Medical Society presents for consideration by the Wisconsin Legislature.

The Council on Scientific Work plans all the postgraduate education courses offered to Wisconsin physicians during the year. Its greatest responsibility is securing the lecturers for the annual meeting each year. T. O. Nuzum, Janesville, was chairman in 1953.

The work of certain ones of these committees will be covered in more detail in a later article.

VA REQUIRES PRIOR APPROVAL FOR USE OF ACTH, CORTISONE

Madison, Sept. 25.—The Veterans Administration Regional Office in Milwaukee has issued a directive stating that physicians who treat veterans with ACTH and cortisone must absolutely have prior approval for the use of the drugs.

A statement issued to the Wisconsin Veterans Medical Service Agency of the State Medical Society states, "We will not authorize any services to a physician who is treating a veteran with these products without having obtained prior approval for their use. We take the position that if we authorize any services, we are in effect giving our sanction to the use of these drugs.

"We must insist upon strict compliance with the VA policy relative to cortisone and ACTH."

Physicians who have any questions regarding this policy are requested to contact Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency, Box 1109, Madison.

La Crosse Offers Degree In Medical Technology

La Crosse, Oct. 10.—The degree of bachelor of science with a major in medical technology is being offered by the Wisconsin State College at La Crosse for the first time this fall.

Students will take the curriculum prescribed for the bachelor of science degree during the first two years and the senior year. The junior year will be taken at an approved school of medical technology such as St. Francis Hospital School of Medical Technology in La Crosse. The school must be approved by both the American Medical Association committee on hospitals and education and the American Association of Clinical Pathologists.

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

215 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

A Forum Feature

No Emergency Service

TRAVELER CLAIMS SOCIALIZED MEDICINE "NOT FOR US"

By Esther Hammill Draheim

That socialized medicine by any other name is not good for Americans is my firm conviction.

I have just returned from a four months' trip to Europe which took me to France, Spain, Majorca, Italy, Switzerland, Austria, Germany, Holland and England. I went primarily to make a survey of low-cost travel for the Appleton Travel Bureau with which I am connected.

One would be thick-skinned indeed not to be sensitive to the currents and cross currents which flow in the life around one while visiting foreign lands.

It was while in England, that beautiful country with its wonderful, courageous people, that I learned about the operation of National Health Insurance—socialized medicine.

Friend Tells Story

I say this because I ran smack into this type of medicine while visiting a friend, an American, living there temporarily. She was recuperating from a serious auto accident and, hearing her story, I marveled that she lived to tell it.

The accident took place in the country a few miles from her home and it was a bad smash-up. My friend was in a very shocked state and suffered severe scalp and face cuts. She and her husband were taken to a nearby doctor's office. There they found a long queue waiting to see the doctor. Her husband supposed she would get immediate emergency treatment but was told by a person in charge that the patient would have to wait her turn. The office was filled with patients.

Found Non-Plan Doctor

This was too much for him, and, after a few heated remarks, he was told that if he wanted immediate attention he would have to contact a doctor not under the plan. (These doctors are commonly known as the "Harley Street Crowd" in London.) The wife was taken home, and a non-plan specialist, highly recommended by a neighbor, was called. She was taken to a hospital where she stayed several weeks receiving treatment for a broken leg and three plastic operations requiring around two hundred stitches. It was very expensive, but worth it.

MRS. DRAHEIM

A word on these non-plan doctors. They are the doctors who did not go under the plan, and all have bigger practices now that pay them much more money than they ever received before socialized medicine. Many English people told me they were so disgusted with the National Health Service set-up that they go to the independent doctor and pay his high fee to get well.

Socialized medicine means that the government has control and operates the medical treatment for people all over the country. The people pay a few shillings a week for their medical care and, in many areas, as many as three to four thousand are assigned to a plan general practitioner. The doctor receives $1.80 a year per patient from the government.

The result is that the doctors often are too rushed to be doctors. Everybody wants to get his money's worth of "free medicine" whether he needs it or not. Often a doctor sees twenty patients in two hours and fills out a blank for each patient. To the hypochondriacs he gives a prescription of harmless pills and sends them on their way, having no time to talk them out of it.

GP is Forwarding Agent

For those really ill, the general practitioner is merely a forwarding agent and one who fills out forms. He has no facilities in his office, has no access to a hospital, nor can he care for his patient in a hospital. He can only send patients to a hospital to be assigned to a specialist, or to a specialist to be assigned to a hospital. Many patients could be treated at home, but they all want to go to specialists now that it is "free." Here again the lineup is encountered and several hours more elapse before the patient gets off the assembly line for a quick treatment such as x-ray and the like.

Cost is Staggering

The cost of this socialized medical plan is staggering. In England, a country of one third the population of the United States, it had cost the government, in three years, (1948–1951) four hundred million pounds, or one billion one hundred million dollars, and the end is not in sight. It has to be paid for somehow. It is not done by the few shillings paid each week by the people, but in taxes which are everyone's burden, including the little man who thinks he has "free medicine." A stenographer in London told me her take-home pay was six to seven dollars a week after taxes!

Esther Hammill Draheim is the wife of State Senator William A. Draheim, Neenah. She successfully operated a restaurant and sporting goods store for six years during her husband's six years of military service, and is now doing promotional work for the Appleton Travel Bureau for whom she made a fact-finding tour of Europe last summer.

Mrs. Draheim is a graduate of Syracuse University and the mother of three children, one of whom is a physician finishing a residency in a Panama hospital. Active in A. A. U. W., she is a past legislative chairman, and a member of the Tuesday Club of Neenah. Her hobbies are "grandchildren, cookery and travel," in that order.

Wisconsin Contributes to National Gain in Voluntary Health Coverage, Survey Shows

Chicago, September 24.—The American people voluntarily increased their protection against the unexpected costs of hospital, surgical and medical care to new record high levels in 1952, the Health Insurance Council reported today in its annual survey of accident and health coverage in the United States. Every section of the country participated in the gains, the Council said.

Wisconsin contributed to this record, with 2,496,000 persons in the state protected against the expense of hospitalization at the end of last year, 2,308,000 against surgical expense, and 999,000 against medical expense.

Over Two Billions

Cash benefits flowing from voluntary health protection aggregated more than $2 billions in 1952, the Council stated in its first public estimate of these figures. About half this amount went to help meet the cost of hospitalization, and over a half billion dollars more went towards operations and doctors' bills. Another half billion dollars represented benefit payments by insurance companies replacing income lost due to accident or sickness. Thus voluntary health protection is now taking care of a substantial part of the nation's health bill, the Council stated.

The total number of persons covered against hospital expense approached the 92-million mark at the end of last year, the Council reported. This represented an increase of more than 5½ million, or 7 per cent, over 1951.

More than 73 million persons were protected against the cost of operations under surgical expense coverage at the end of 1952, the Council said. This figure represented an increase of more than 7½ million persons, or 12 per cent, over the year before.

Approximately 8 million more persons than in 1951 were protected against doctors' bills under medical expense coverage at the end of last year, the Council stated. This increase brought the total number of persons so protected to nearly 36 million and represented an increase of 29 per cent over 1951.

The number of persons protected against loss of income due to disability exceeded 38 million at the end of last year, a new high mark, the Council stated.

The year likewise saw increasing public acceptance of major-medical expense coverage, the newest form of voluntary health protection designed to help meet the catastrophic costs of very serious illness. Nearly 700,000 persons had this form of protection at the end of last year, the Council stated.

Broadly speaking, major-medical expense coverage takes up where the customary forms of health protection—hospital, surgical and medical care—leave off. It provides maximum benefits ranging from $2,500 to $10,000. This maximum may apply to any one illness, to any one family member, or to the total payable in any one year. To keep the cost of this protection down, major-medical expense coverage is written with a deductible feature, as is automobile collision insurance. Likewise, through co-insurance, it makes the person protected responsible for a share of the costs of care above the deductible amount, thus encouraging the use of only such health services as are really needed.

Shows Public Interest

"The development of major-medical expense coverage," the Council stated in its report, "is further evidence of the willingness of the insurance business to experiment in the public interest and to take steps to meet a recognized public need. It testifies to the alertness of the companies writing accident and health protection in recognizing the need for broader coverage than had heretofore been available, and thus reflects the inherent vitality of the voluntary health movement in this country."

Organizations covered in the Council report include insurance companies, Blue Cross, Blue Shield and various other independent plans sponsored by business and industry, employee benefit associations, and private group clinics.

The Council is an organization of nine associations in the insurance business made up of companies writing the various forms of protection against hospital and medical costs and the loss of income due to disability. Its members are: American Life Convention, American Mutual Alliance, Association of Casualty and Surety Companies, Association of Life Insurance Medical Directors, Bureau of Accident and Health Underwriters, Health and Accident Underwriters Conference, International Claim Association, Life Insurance Association of America, and Life Insurers Conference.

EISENHOWER BACKS FUND CAMPAIGN

Oct. 2.—President Eisenhower has termed the financial crisis facing most medical schools "a dangerous threat to the national welfare, which must be met."

The President opened the $10,000,000 campaign within industry and the medical profession by writing a long letter to S. Sloan Colt, New York banker and president of the National Fund for Medical Education.

The letter stated that "the financial problems of the medical schools should be solved through private, rather than governmental means. Excessive reliance on government violates the essential principle of our free enterprise system. It falls, then, upon American business to assume a greater share of the responsibility for maintaining the institutions essential to our national health."

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

Court Rules Statute of Limitations Does Not Apply to Professions

Madison, Sept. 15.—Circuit Judge Herman W. Sachtjen reversed a decision made by Small Claims Court Judge Douglas Nelson for dismissal of a suit brought by Dr. Stuart A. McCormick, Madison, against a patient who owed him $203.

Judge Nelson had dismissed the suit on the grounds that the two-year statute of limitations had run out. The statute states, however, that "any action to recover unpaid salary, wages or other compensation for personal services, except fees for professional services," must be commenced within two years.

Calls Exemption Vague

Judge Nelson held that the purported exemption for professional fees was "vague, indefinite, and uncertain, and an improper classification." He declared it to be unconstitutional.

Judge Sachtjen rebuked Judge Nelson for his contention, saying that a hardship would result if professional persons were limited to a two-year period in which to collect debts.

"Execution of the power to declare laws unconstitutional by inferior courts should be carefully limited and avoided if possible," stated Judge Sachtjen.

He pointed out that it was a better practice to assume laws constitutional until the issue was determined by a court of appellate jurisdiction.

The case was remanded back to the Small Claims Court for trial on its merits.

New Course of Exercise Therapy Rehabilitates VA Hospital Patients

Washington, Sept. 20.—Veterans Administration doctors have come up with a new "third dimension in medicine" which, they claim, goes one step beyond prevention and cure.

According to Douglas Larsen, as quoted in the La Crosse *Tribune*, the VA is hopeful that this new concept of treatment, which is basically exercise, will cut the patient load of their hospitals enough to end growing demands that only veterans with service-connected ills be treated in VA hospitals.

The idea is being applied especially to psychiatric and chronic cases, which account for the great bulk of the VA hospital population.

"Involves Modern Concept"

According to Medical Director Joel T. Boone, "It involves a modern concept of medical restoration, which, following the preventive and curative phase, is unfolding before our eyes a new horizon with new opportunities for service, new challenges for science, and a better way of life for the tens of thousands of sick people in our civilian and veteran population."

In the VA's Ft. Howard, Md., hospital, the rate of discharge of chronic patients has now been raised to equal the number of chronic patients admitted. Other veterans' facilities are being surveyed for their results.

An important facet of the treatment is getting the patient interested in helping himself by means of exercises.

All Washington–Ozaukee Members Contribute to Medical Education Fund

Madison, Aug. 14.—The Washington-Ozaukee County society is responsible for 31 of the 81 gifts received by the American Medical Education Foundation from Wisconsin physicians last year.

This society passed a rule adding ten dollars to the county dues of every physician as a contribution to the fund. By this means, a comparatively small society was enabled to make a $320 contribution.

Wisconsin is Twentieth

In the number of contributions made, Wisconsin ranked twentieth among the 48 states, falling behind Alabama, Colorado, Connecticut, Iowa, Maryland, Michigan, Nebraska, New Hampshire, South Dakota, Vermont, Virginia and Washington as well as the most populous states.

In the size of the state's contribution, Wisconsin was twenty-ninth, falling behind Delaware, Florida, Georgia, Minnesota, Montana, New Jersey, Oregon, Utah, and West Virginia, in addition to the above-mentioned states.

Indiana led all states both as to number of contributors and size of contribution, with 1,217 members giving a total of $58,152.

Led only by Indiana and the high-population states of New York and Pennsylvania in number of contributors was Nebraska with 474, and this low-population state contributed more money than Pennsylvania, ranking third behind Indiana and New York.

Wisconsin physicians in the number of 630 have made direct personal contributions to medical schools.

Wisconsin Special to San Francisco

Planning to go to the Annual Session of the American Medical Association in San Francisco next June 20–25?

If you or your family plan to attend the House of Delegates meeting or the technical or scientific exhibits of the AMA session in San Francisco, you may be interested in adding to the enjoyment of your trip by traveling on a special car of the Streamliner set aside for Wisconsin physicians and their families.

The Streamliners leave Chicago daily and arrive in San Francisco the second day out—one business day en route.

If you are interested in arranging rail transportation to San Francisco with a group of Wisconsin physicians and families, please write the State Medical Society, Box 1109, Madison, Wisconsin. If enough physicians express an interest in this possibility, further steps will be taken to arrange group transportation.

Racial Segregation Is Ending in VA Hospitals

Washington, Sept. 18.—VA Administrator Harvey Higley states that his agency is acting "as rapidly as possible" to eliminate segregation in its hospitals.

"We hope the day is not far removed when there will be no semblance of racial segregation in VA hospitals," he stated. He added that a too abrupt change might have adverse medical consequences on some patients, particularly neuropsychiatric ones.

Need A Good Public Relations Booklet?

The inspirational inaugural address of Dr. Edward J. McCormick, Toledo, Ohio, newly-installed president of the American Medical Association, sums up the activities of American medicine during the past year as well as its hopes and aspirations for the future health of the American people.

Every doctor can use copies of his speech for many purposes—patients—friends—newspaper and radio representatives — hospital people — others. (Attractive booklet 8½" x 5½", 10 pages.)

Order your copies now in any quantity from the State Medical Society, P.O. Box 1109, Madison, Wisconsin.

ALL COPIES FREE.

HIGH SCHOOL ESSAY CONTEST SCHEDULED

Chicago, Sept. 10.—The Association of American Physicians and Surgeons, Inc., has announced its eighth annual national essay contest for high school students on the subject "why the private practice of medicine furnishes this country with the finest medical care."

Stimulates Thinking

The contest is designed to stimulate anti-socialist thinking on the part of high school students. It offers a first prize of $1,000, second and third prizes of $500 and $100, and three additional prizes of $25 each.

Essays for this contest must be limited to 1,500 words and must be submitted between the dates of January 1 and March 1, 1954. County societies which wish to sponsor the contest in their communities may write to the State Medical Society office for additional information. Children of MD's may not compete.

Dr. W. C. Stewart, Kenosha, is a member of the AAPS National Essay Contest Committee.

U. S. TREATY POWERS MAY THREATEN CITIZENSHIP REQUIREMENTS FOR MD'S

Washington, Sept. 10.—The treaty-making powers of the United States are seen by some medical authorities as a possible threat to the rights of states to determine their own criteria for the licensing of physicians.

Eleven states require that an applicant for licensure have his first papers, signifying his intention to become a citizen. Wisconsin is one of these. Twenty-two others require applicants to be United States citizens.

Since treaties are supposed to be binding on the country as a whole, and since treaties are based upon mutuality, a foreigner could theoretically apply for license under the terms of the treaty, and the state's citizenship requirement could be superseded.

In recently negotiated treaties with Israel, Denmark, Greece, Germany and Japan, there is a reservation which would prevent this complication. The treaty with Israel states, "Nationals of either party (the United States and Israel) shall not be barred from practicing the professions within the territories of the other party merely by reason of alienage; but they shall be permitted to engage in professional activities therein upon compliance with requirements regarding qualifications, residence and competence that are applicable to nationals of such other party."

Treaties with the other nations listed above have similar provisions, but there are older treaties in force with other nations which have no such provision. The State Department does not intend to renegotiate such treaties to include the provision. It states that there have been no difficulties because undesirable applicants can usually be eliminated on grounds other than those of citizenship.

J. W. Foristel, legal counsel of the Washington office of AMA, quotes a State Department source as saying that if any state licensure board should be involved in litigation over this point, the State Department will not hesitate to furnish minutes of treaty negotiations which would illustrate the intention connected with any reciprocity agreements.

Latest in Drive-Ins Is Drive-In Hospital

Morgantown, Ky., Oct. 6.—A doctor's ingenuity has combined with a small town's need for a hospital to set up a sort of drive-in hospital in this rural community.

The doctor, D. G. Miller, Jr., has converted two small country stores into a hospital where patients are in and out the same day.

His staff consists of two nurses, a laboratory technician and a receptionist, and they handle everything except major surgery. There is no board or room charge at the "hospital." If a patient stays long enough for meals, relatives go out and buy food.

Dr. Miller is one of two physicians in a low-income county. He contends that his system utilizing capable assistants and proper, though sometimes improvised, equipment, enables him to meet the needs of all but three per cent of his patients.

Pigskin and PR Prove a Potent Combination

Lynchburg, Va., Oct. 10.—Lynchburg physicians turn football season to good public relations account by means of a system of their own.

Each year, members of the Lynchburg Academy of Medicine perform complete physical examinations for members of the local high school football squad, and also arrange for a doctor to be in attendance at every game, at home and away.

The high school coach notifies the academy each fall when football practice is about to begin. A special day is set on which five academy members go to the football stadium, examine all players free of charge and issue health certificates.

Two doctors sit on the bench at all home games, and another is provided for the opposing team if they request it. When the team plays away from home, either a Lynchburg doctor accompanies the squad or the public relations committee of the academy makes arrangements with a doctor in the town where the game is played to attend the Lynchburg team. Families of the players have expressed great appreciation of this service.

OFFICERS OF THE WOMAN'S AUXILIARY to the State Medical Society are, left to right, Mrs. H. H. Wright, Milwaukee, vice-president; Mrs. Victor Falk, Edgerton, president-elect; Mrs. C. R. Pearson, Baraboo, president. At the extreme right is Mrs. Leo J. Schaefer, Salina, Kans., president of the Woman's Auxiliary to the AMA. Milwaukee Journal photo.

Number of Graduates, Student Enrollments in Medical Schools Reach All-Time High

Chicago, Sept. 11.—Enrollments in the country's 72 medical and seven basic science schools during the past school year have reached an all-time high. The number of medical graduates of last spring also constitutes an all-time record.

These facts are disclosed in the 53rd annual report of the AMA's Council on Medical Education and Hospitals. The report states that there were 27,688 students enrolled in these schools during 1952–53 while 6,668 students were graduated. The latter figure exceeds by 279, or 4.4 per cent, the previous record established in 1947 when wartime acceleration had caused several schools to graduate more than one class.

Will Be More Graduates

The estimated number of graduates for 1953–54, based on enrollments reported for senior classes, is even greater—6,831.

For the first time in five years, there was a slight decrease in the size of the freshman class of medics entering school last fall. There were 7,425, or 16 less than the record class of 1952–53.

In addition to full-time medical students, 140 part-time and special students working toward an M.D. degree were enrolled in medical schools, and an additional 407 were in internships that were a part of degree requirements of their medical schools.

There were 1,463 women in schools during that period, and 715 negro students. There were 7,942 veterans enrolled, comprising 28.7 per cent of the total student body as compared to 42.2 per cent the year before. Thirty-six of the veterans were women.

For the fourth consecutive year, the number of applicants for admission to medical schools has gone down—16,763 as against 19,920 in 1951–52.

Difficulty Exaggerated

The report claims its figures emphasize the fact that the difficulty of gaining admission to medical schools has been greatly exaggerated. There were only 2.6 applicants for each place in schools which is comparable to the year 1929–30. One factor is the disappearance of the large backlog of veterans who completed their premedical training following the end of World War II. Another, which causes serious concern to medical educators, is the sharp decrease in the number of applicants with superior academic records.

Further Increases

The report states that "there will be further, significant increases in enrollments when certain established schools complete expansion programs that are now under way, and when several new schools, now in the final stages of development, are completed."

To help alleviate the financial difficulties of the medical schools, the National Fund for Medical Education and the American Medical Education Foundation have solicited and distributed more than $4,750,000 in unrestricted grants to medical schools since July, 1951, and hope to be able to provide at least $10,000,000 annually to aid schools in meeting the operating costs of their educational programs.

25 PHYSICIANS NAMED TO COMMITTEE POSTS

Milwaukee, Oct. 5.—Dr. H. Kent Tenney, newly installed president of the State Medical Society, appointed 25 physicians to committee posts for the coming year. The appointments were made to fill vacancies created by resignations or expirations of terms in office.

The following appointments were announced:

Cancer:

Dr. R. P. Welbourne, Watertown, chairman
Dr. W. S. Bump, Rhinelander
Dr. J. E. Conley, Milwaukee
Dr. G. I. Uhrich, La Crosse
Dr. Lucille Radke, Barron
Dr. R. J. Schacht, Racine.

Grievances:

Dr. R. E. Fitzgerald, Milwaukee, chairman
Dr. E. W. Mason, Milwaukee
Dr. E. D. Sorenson, Elkhorn.
Dr. James Moffett, Platteville
Dr. C. D. Neidhold, Appleton
Dr. C. B. Hatleberg, Chippewa Falls

Hospital Relations:

Dr. A. H. Barr, Port Washington, chairman
Dr. William R. Kreul, Racine
Dr. R. S. Haukohl, Milwaukee

Medical Education and Hospitals:

Dr. T. L. Squier, Milwaukee, chairman
Dr. Norman Clausen, Madison

Coordination of Medical Services:

Dr. J. F. Wilkinson, Oconomowoc, chairman
Dr. Roy Larsen, Wausau

Council on Medical Service:

Dr. D. E. Dorchester, Sturgeon Bay, chairman
Dr. T. D. Elbe, Thiensville
Dr. D. N. Goldstein, Kenosha
Dr. J. F. Maser, Rice Lake

Public Policy:

J. M. Sullivan, Milwaukee, chairman
J. R. Schroder, Janesville

Council on Scientific Work:

Dr. L. G. Kindschi, Monroe.

Minutes of the Council Meeting, Madison May 23 and 24, 1953

1. Call to Order

The Council was called to order by Chairman Arveson at 3:00 p.m., Saturday, May 23, at the Loraine Hotel, Madison.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Kidder, Arveson, Bernhart, Casper, Wegmann, Zellmer, and Chairman Emeritus Gavin.

Also present were President Griffith; President-Elect Tenney; Speaker Forkin; Vice-Speaker Fons; Treasurer Weston; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association (Saturday only); Dr. W. D. Stovall, AMA delegate; Dr. R. S. Baldwin, medical editor, *Wisconsin Medical Journal* (Saturday only); and Dr. J. M. Sullivan, editorial director, *Wisconsin Medical Journal.*

Staff members present were C. H. Crownhart, secretary; Roy T. Ragatz, assistant secretary; Earl Thayer, director of public information; R. B. Murphy, legal counsel; Mrs. Dorothy P. Reinhardt, assistant editor, *Wisconsin Medical Journal;* and Miss Joan Pyre and Miss Jean McGruer of the Society's office.

3. Approval of Minutes

Approval of the minutes for the February 28-March 1 meeting was laid over until the July meeting of the Council inasmuch as they are to be published in the June issue of the Journal.

4. Wisconsin Medical Journal

By direction of the Council at a prior meeting, a special report was made of the *Wisconsin Medical Journal* and its publication. Dr. R. S. Baldwin, medical editor, and Dr. J. M. Sullivan, editorial director, together with staff members concerned with this activity, presented various aspects of the Journal, its procedures and policies. Mrs. Dorothy Reinhardt, assistant editor, gave a detailed report of activities in assembling the Journal, showing examples of original papers, advertising copy, page proofs, and a final "dummy" ready for printing.

As advertising manager, Roy Ragatz reviewed the advertising policies of the Journal and emphasized the necessity for working in close harmony with the American Medical Association in order to have consistent adherence to the ethical policies established by it.

The problem of obtaining and selecting material for scientific articles is under the jurisdiction of Doctor Baldwin, as medical editor. He discussed the methods of editing the articles submitted and his concern as to the future of the scientific section—pointing out what appears to be a diminishing interest in this section of the Journal and the need for encouraging more authors to submit material. He also expressed concern as to the number of scientific articles which are "lost" because they are published only within clinic or hospital groups, and thus not listed in *Index Medicus.*

Earl Thayer had prepared displays entitled "Who Reads the Journal?" and "As Others See Us" as a survey to indicate how well the Journal is being read. There were interesting comments from individuals and organizations in response to the Medical Forum, requests for material, and letters concerning other sections of the Journal.

Dr. J. M. Sullivan, editorial director, discussed the editorial policy of the Journal and asked direction of the Council as to proper subjects for creation of reader interest. It was the general opinion of Council members that in addition to recognizing the need for stimulating reader interest, the editorial policy of the Journal, as its official publication, should be a reflection of the opinion of the State Medical Society and its membership as a whole, rather than that of an individual member or group of members.

5. Report on New Building

The secretary reported on the preliminary work being done by Mr. Allen J. Strang, architect for the new building. A descriptive summary of all activities within the society building was provided Mr. Strang, who also interviewed the entire executive staff in order to enable him to make the appropriate planning for integration of administration.

Mr. Murphy, as legal counsel, reviewed the details in connection with the organization of the SMS Realty Corporation (authorized at the previous Council meeting) to hold title to the real property of the State Medical Society and provide the device for financing.

In his review he discussed the articles of incorporation, as to name, purpose and powers, trustees, officers, and disposition of income and assets, which had also been discussed previously with the Interim Committee and House Planning Committee, and recommended that the Council, as governing body of the State Medical Society, authorize the transfer to the realty corporation of all Society-owned real estate and property. With the approval of such procedure the corporation will be organized and the Council, at its July–August meeting, will hold a separate meeting as the corporation's members, and elect a board of directors and other officers, and take necessary steps to support the financing of the new building.

On motion of Doctors McCarey–Bernhart, carried, the Council authorized transfer, for $1.00 and other good and valuable consideration, to the SMS Realty Corporation as its organization is completed, of all realty owned by the Society and of its furniture, fixtures, and office equipment, not including cash or securities.

6. Annual Session of the American Medical Association

By direction of the Council, a May meeting precedes the annual meeting of the American Medical Association for the purpose of considering such matters as are known to be scheduled for action by the AMA, and for advising and instructing the Wisconsin delegation

It appears certain that one matter to come before the House of Delegates for discussion is that of division of fees, in response to recent publicity on the subject.

It has been recommended by the Interim Committee that, in an effort to make a temperate statement and avoid further public conflict on the subject, attention be directed by the Wisconsin delegation to the fact that the Principles of Medical Ethics as interpreted by the American Medical Association reflect the medical profession as a whole and not a segment of it.

On motion of Doctors Bell–Fox, carried, the following resolution was adopted by the Council for introduction to the American Medical Association House of Delegates in June 1953:

WHEREAS, it has become the practice of some organizations of various groups within the profession of medicine to state and interpret codes of professional ethics, and

WHEREAS, such practice tends to develop statements in different wording, leading to varying interpretations, now therefore be it

RESOLVED, that the Principles of Medical Ethics as stated, interpreted, and applied by the American Medical Association shall be considered as the only fundamental and controlling application of ethics to this profession, and any statement by organizations within the general profession of medicine be considered by the members of the American Medical Association as advancing only views of a particular group and as without official sanction of the entire profession as represented by the American Medical Assocaition.

The Council reviewed a number of other resolutions referred by various county and state medical associations, and concerning the federal administration's "Reorganization Plan No. 1" (elevation of the Federal Security Agency to departmental status), Social Security coverage, and changes in requirements for approval of hospitals for internships. The resolutions were considered at length, but no formal action was taken upon them.

7. Legislative Report

The secretary and legal counsel reviewed major legislative proposals and their progress to date. Much of the discussion was directed to Bill 334, A., relating to dangerous drugs, and Doctor Sullivan, as chairman of the Committee on Public Policy, reported on a conference he had held with representatives of the Wisconsin Pharmaceutical Association. A portion of the bill is intended to bring the Wisconsin law into conformity with the new federal legislation with reference to oral prescriptions, the use of the telephone, etc., to which there is no objection on the part of the State Medical Society. However, the bill would also repeal the present definition of dangerous drugs and would restate the definition of them, with the effect of adding thousands of drugs within the definition of "dangerous drugs."

Objection has been taken to the latter part of the bill since the Pharmaceutical Association has taken the position that a portion of the law defining dangerous drugs prohibits an employee of a physician from selecting, measuring, counting, packaging, or labeling such medications as the physician directs.

The Council, on motion made, seconded, and carried, approved the position of the Committee on Public Policy that no additional listing of dangerous drugs be included in the present law.

8. Historical Committee

The following report was submitted on behalf of the committee by Mr. Crownhart:

This committee, with Doctors Tenney, Dessloch, Tallmadge, Minahan, and Kidder present, met May 3, with Messrs. Lord and McNeil as guests, and took the following action:

(a) Elected W. D. Stovall, M.D., Madison, chairman of the new Section on Medical History; P. R. Minahan, M.D., Green Bay, vice-chairman; the secretary of the Society as secretary–treasurer.

(b) Left vacant for appointment by the general chairman the following positions:

Manuscript chairman
Collection chairman
Membership chairman

(c) Established annual dues, voluntary, at $5.

(d) Established fiscal year, July 1–June 30.

(e) Referred to the section officers the following projects:

(1) Development of a work of medical history for long-time planning.
(2) Periodic bulletins for profession and general public.
(3) Development of a cooperative program between state and local organizations relative to institutional history, local medical society history, and history of various medical personalities.

(f) Referred to the section officers preparation of an exhibit at the next annual meeting.

(g) Preparation of exhibit for auxiliary meeting.

(h) Consideration of presentation of special paper on medical history at each annual meeting.

(i) Development of Fort Crawford project.

(j) Authorized preparation of descriptive brochure and membership certificate.

A detailed report, which follows, of the State Medical Society project to date was discussed by Dr. C. L. Lord, director of the State Historical Society, who pointed out that on the occasion of the second anniversary of the project, it was an appropriate time to take stock of what had been accomplished. He said, "We have not only acquired a considerable amount of material on the history of medicine in Wisconsin, not only stirred up interest and appreciation in this field, but we have set the stage for continued cooperation between the two organizations."

Report to the State Medical Society on the Medical History Project

The State Medical Society has launched an unparalleled experiment into the collecting of "grass-root" medical history materials. During the two-year project a significant beginning has been made. The State Historical Society plans to continue the project as part of its general collecting and preservation policies without further financial aid from the State Medical Society. The role of the State Medical Society has been to initiate the venture, and now that the Medical History Project has been incorporated into the regular program of the State Historical Society, continuity is assured to the collecting of valuable manuscripts and to the stimulation of interest in medical history. All collections acquired by the State Historical Society pertaining to medical history will, in future years, be placed in the State Medical Society's Medical History Collection.

A brief recounting of some of the problems and adventures might be made in this terminal report of the two-year project.

A contact list of people who might have medical history manuscripts was prepared from names sent in by the secretaries and presidents of local medical societies. Where initial leads were lacking, an inquiry at any doctor's office or at the local newspaper brought forth not only the names of pioneer doctors, both living and dead, but also names of descendants, relatives, and friends of doctors who might help in our search for materials. The State Medical Society sent us copies of their letters to relatives of deceased physicians who were over 70 when they died and the relatives were contacted. Once begun, the contact list has continued to grow until we now have more than 300 leads in the file ready to be followed up, excluding the several hundred leads which we have exhausted—either by learning that there was no material available or else by adding the manuscripts to the collection.

Publicity on the search took several forms. Notices in the green section and a historical article in the *Wisconsin Medical Journal* told doctors of our search for manuscripts. When we collected a set of manuscripts, news releases were sent to all newspapers in the county of origin. Speeches at the Summer Institute and the 19 regional meetings of the State Historical Society, as well as attendance at one scientific regional meeting of the State Medical Society, helped spread the word of our search. An exhibit at the annual meeting of the State Medical Society also aroused interest. Items were also carried in the Historical Society's newsletter and magazine.

The best publicity came from the personal contact with doctors, friends of history and medicine, and descendants of pioneer physicians.

Each lead, derived either through the publicity program or an actual contact, had to be carefully followed up. For instance, during an interview a doctor might suggest the name of an old pioneer doctor who had died 15 years earlier, and recommend seeing the old settler's daughter, who lived in town. A call on the daughter might reveal that if any manuscripts had been saved her brother would have them. The brother in turn might remember having passed the papers on to his son, who, more likely than not, lived in another town or another state. When the papers start passing through the hands of attorneys, local collectors, in-laws, etc., the tracing of a doctor's manuscripts can become complicated.

As the medical history collection grew, we were able to be more selective in our collecting. We now have a sizable number of account books, etc., and are able to choose only such business records of doctors as will show the changing practice and economics of the medical profession all over the state. Thus we have the twin problems of chronology and geography. We want a collection covering medical practice from the beginning of the territory to the present and covering every area of the state. But the records we accept should be representative collections—we cannot save every ledger ever kept for the 1890's, for example. Eventually, we hope to have collections of all kinds which will represent the entire state as well as every time period in our history. We are already well along the road to that goal.

While we are now in a position to be able to engage in selective collecting, especially of business records, other manuscript materials have been more difficult to find. Letters and diaries of physicians are particularly elusive and there is the ever-present problem of convincing the families and friends of doctors that the personal papers will often shed significant light on the development of the medical profession.

Extensive letter writing helps lay the groundwork, but a personal visit to the owner of the collection is the most important and rewarding stage of the collecting process. Even though the Medical History project received manuscripts from as far away as Boston and Los Angeles, most of the collections were obtained after personal interviews with the owners of the material. Along with the personal interviewing for manuscripts, we made

some tape recordings of older doctors, though we found that, like most people when a microphone is placed before them, they were interested in talking for posterity and tended to ignore or gloss over many of the pertinent questions asked them about such things as medical organizations, early practices, and competition and the growth of public health.

The first two years of the Medical History Project were educational ones; the results will continue to show up for at least the next decade. First, people have to be convinced that the "junk" they have in the attic is important. Secondly, they have to have the exact types of medical manuscript material spelled out for them. On a number of occasions I followed up a lead on a collection of "manuscripts" that told "all about doctors" and found county histories or back issues of the medical journal awaiting me. I soon learned to say we would like to have "letters to and from doctors" rather than "correspondence files"; "old ledgers, journals, account books" rather than "business records"; and "minute books and letters of the local medical society" rather than the "organization records."

Besides an explicit vocabularly, patience, too, is required in the search for medical manuscripts. One collection, including the correspondence and diaries of the doctor who reorganized the State Medical Society shortly after the Civil War, Henry Youmans, is still in the hands of one of the descendants after almost two years of negotiations—even though no definite refusal to deposit them has been received. Several excellent collections of pioneer rural practitioners were obtained after 12 or 15 personal calls on the owners extending over a period of 8 or 10 months. Many local medical societies had to secure approval of their memberships before depositing the old minute books in the Medical History collection, and the negotiations often carried on for a year or more.

As in all manuscript searches, the people who have valuable historical documents and regard them as trash are counterbalanced by those who have junk and believe they have goldmines. In all cases, people were treated as if they owned goldmines and the results were rewarding.

Besides the 86 major accessions to the Medical History Project, we have about 300 leads yet to be run down. Each of these is apt to lead to more. They are incorporated into the lead file of the State Historical Society and will be tracked down in the coming months. We have located some material which can be used by scholars but which has not been collected. For example, the Hardware Mutuals Insurance Company of Stevens Point have their complete correspondence files pertaining to the inauguration of the insurance plan with the State Medical Society, and have agreed to keep it in fireproof quarters and make it available to scholars. The records of the State Medical Society will be gone over for the historical documents which should be saved. This is planned for the near future.

The important thing about the Medical History Collection, even though there has been a good start both collection-wise and publicity-wise, is that the project has been initiated and the benefits will continue to accrue for years to come. There have been collections including manuscripts of famous men and there have been collections which depict the life of the average practitioner. The time element as well as geographical distribution has been considered in the collections.

I should like to add a special word of praise for Wisconsin doctors. Generally they have been extremely cooperative, both individually and through their local organizations. Similarly, the State Medical Society office has devoted much time and effort to the project. I appreciate their help.

Respectfully submitted,

/s/ Donald R. McNeil

On motion of Doctors Costello–Wegmann, carried, the report of the Historical Committee was approved by the Council.

9. Report of the Interim Committee

The following report of the Interim Committee was presented.

In its May 22, 1953, session, the Interim Committee considered a number of matters and reports the following for Council action:

Provident Group Disability Plan

The following changes in coverage and administrative procedures are recommended for the new policy year beginning in August 1953:

a. Payment of time loss benefits during hospital confinement within the first 15 days of disability.

An experience report from the insurance company indicates the loss ratio of premiums earned and losses incurred is slightly over 82 per cent.

At present there is a 15-day waiting period for disability benefits unless the physician is hospitalized, in which case benefits begin with that date even though the claimant is not hospitalized a total of 15 days.

It is recommended that future disability payments during the 15 days be made only for those days in which the physician is actually confined in a hospital.

Figures indicate that a saving of about $21,000, or a 4 per cent reduction in losses, would have resulted if no payment had been offered for the days during which physicians were not hospitalized.

b. Hospitalization in federal or state institutions.

It is recommended that no hospital indemnity payments be made in instances where an insured member is confined in a federal institution or a state institution where confinement there is *without cost* to the individual. This would not exclude payments for hospitalization in a federal or state institution where the insured received a charge. It should also be pointed out that this recommendation

refers to hospital benefits only, and would not affect weekly indemnity benefits.

c. Addition of partial disability for sickness following payment for total disability.

The present contract allows for payments when a member is totally disabled as a result of sickness, but there is no partial disability provision. There have been instances where it has been difficult to settle a claim when a disabled physician returns to partial practice and it is necessary to determine the termination of total disability.

It is felt that the addition of a partial disability benefit would be of advantage to the insured members and to the insurance company.

It is therefore recommended that the contract be amended to include a partial disability payment provision, at one-half the total disability benefit in instances where total disability payments have existed for at least 30 days, such partial disability benefits to be limited to 26 weeks. The total additional premium cost would be 10 per cent, or $127.60 annually.

d. Increase in weekly benefit for members under 60.

It has been proposed that an additional weekly benefit of $25 be made available to members under 60, on an optional, selective basis. Initially, the application would contain certain medical questions on which the company would make selection.

To avoid any unfavorable effect upon loss ratios, it would be necessary to limit such addition to those persons whose total benefits from this type of coverage in a professional group do not exceed $150. This provision does not apply to personal insurance planning.

On motion of Doctors Kasten–Hill, carried, the recommended changes in the Provident Plan were approved by the Council.

Educational Membership

For the past two years consideration has been given to the subject of a special membership, with a lower amount of dues, for those physicians engaged in full-time teaching in the basic sciences and not engaged in the active practice of medicine.

It is recommended that the following resolution be considered but that the matter be laid over for action at the next meeting of the Council:

WHEREAS, there are physicians in Wisconsin engaged full time in the teaching of the basic sciences or in other full-time teaching activities, and

WHEREAS, the earned income of these physicians is seldom comparable to that of the practicing physicians and does not afford the ultimate potential of private practice, and

WHEREAS, some such physicians, while retaining membership, feel that the payment of dues in the amount charged those in the full-time practice of medicine is too severe a financial burden, and others state that they are not members because of that burden, and

WHEREAS, it is to the public health advantage of the people of Wisconsin and to the good of the profession that these physicians be associated with their brethren in the professional organizations of medicine and surgery, now therefore be it

RESOLVED, that Chapter VIII, Section 4 of the By-Laws be amended as follows, such amendment to take effect on January 1, 1954, with prior notification being provided all secretaries of county medical societies:

Educational Memberships. Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

On motion of Doctors Fox–Hill, carried, the subject of a special educational membership was laid over for consideration and action at the July meeting.

License Revocation and Membership Status

Chapter XI, Section 3, of the Constitution and By-Laws contains a provision reading, "A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation."

That was enacted prior to a change in the statutes permitting the suspension of a physician's license. There appears to be no provision regarding automatic revocation of membership upon suspension of a license to practice.

The Interim Committee recommends to the Council that it offer the House of Delegates a proposal that the By-Laws be changed to provide for automatic revocation of membership in the Society in instances where a physician's license to practice medicine has been suspended.

On motion of Doctors Dessloch–Bernhart, carried, the Council acted to refer the proposal to the House of Delegates.

10. Report of the Audit and Budget Committee

Doctor Dessloch, as chairman of the Audit and Budget Committee, presented its report, as follows:

In its meeting Saturday morning, May 23, 1953, the Audit and Budget Committee:

a. Reviewed the *audit* of the Society's financial affairs for 1952 and reports to the Council its commendation of the certified public accountant for a comprehensive and satisfactory audit which shows the Society affairs to be in sound condition. Summary of the more important sections of the report will subsequently be distributed to the Council.

b. The *Section on Radiology,* which in the past has received some financial support by the State

Medical Society in connection with scientific activities, requests approval of the replacement of obsolete viewboxes with the State Society carrying one half of the cost, amounting to $325, the Section members carrying the balance.

On motion of Doctors Bell–McCarey, carried, the Audit and Budget Committee approved this expenditure as a charge to the annual meeting account.

c. In connection with the annual meeting, there will be a special *art exhibit* of extensive character, a project under way in cooperation with the Milwaukee Art Institute for almost two years. In addition to providing a speaker, the State Medical Society has been requested to assist in financial support.

On motion of Doctors McCarey–Fox, carried, an appropriation of an additional $500, to be charged to the account on health exhibits and conferences, has been approved.

d. The committee received a detailed report of expenses in connection with the *dedication* of the *State Laboratory of Hygiene*, amounting in total to $728—well under the $1,000 approved for this special occasion.

e. The third floor of the present office building now accommodates, in restricted quarters, 16 employees, and the recommendation of the secretary was that physical circumstances are such that this space should be *air conditioned* by two units that may be removed to the new building at such time as that is required.

The committee unanimously authorized this project.

f. The operation of the *Wisconsin Plan* is under direction of the Commission on Prepaid Plans. Costs incurred by the Society are prorated to the participating companies.

In view of the character of this operation and the fact that the Commission on Prepaid Plans is in specific charge of it, the Audit and Budget Committee unanimously recommends that the accounting procedures be transferred from the Society general operations to the books of the Commission.

In addition, the committee reviewed other matters including procedures for authorization of travel time, staff members' reporting of expenses, and similar details on which it made recommendations of an administrative character not requiring approval by the Council.

Approval was given to the report of the Audit and Budget Committee on motion of Doctors Bernhart–Kidder, carried.

11. Report on Selective Service and Doctor Draft Law

Doctor Weston, as chairman of the Committee on Selective Service, reported on the current status of the various priority groups of physicians. He spoke of the problems in making recommendations as to availability and essentiality of individuals because of constantly changing regulations and pressure from Washington, and said the committee had tried very carefully to keep the recommendations equal in all areas.

Earl Thayer discussed the status of the extension of the Doctor Draft Law (the House bill) and pointed out, in particular, new amendments or proposals which would give credit for time spent during World War II by conscientious objectors, and which would broaden the authorization for giving higher commissions and grades "commensurate with professional education or ability." The bill would also provide that a man with 12 months prior service since September 16, 1940, could be called for only 17 months.

12. Woman's Auxiliary—Nurse Recruitment Program

Mrs. Victor S. Falk, Jr., representing the Woman's Auxiliary, appeared before the Council to discuss the nurse recruitment program, explain completed projects, and request support of the Council in determining an approach for the future.

Mrs. Falk discussed the critical nurse shortage and pointed out the work done by the Auxiliary in its program started in 1951. She said that numerous recruitment technics have been employed and many recruitment resources tapped; that the auxiliaries have sponsored career planning programs for prospective students and their parents, conducted hospital tours, promoted newspaper publicity, shown nursing films to adults and pupils, in addition to offering more than 40 scholarships and loans to deserving future nurses, amounting to almost $6,000. The auxiliaries have compiled and distributed nearly 500 Nursing Reference Notebooks to Wisconsin's secondary schools and have participated in high school "Career Day" programs. A projected plan of the auxiliaries is the organization of Future Nurse Clubs, and Mrs. Falk spoke of plans to continue the nurse recruitment program and expressed the need for clerical assistance in carrying out the program. She said, "Since the Auxiliary lacks headquarters and adequate facilities, we must rely upon you to share the address of 704 East Gorham Street with us."

It was moved by Doctor McCarey, variously seconded and carried, that the State Medical Society offices be made available as headquarters to the Woman's Auxiliary, that the staff provide secretarial assistance and files to aid the recruitment program, and that the staff report back to the Council in November as to the volume of work entailed.

13. Commission on Prepaid Plans

At the request of Chairman Arveson, Doctor Dessloch summarized the Quarterly Report of the Commission on Prepaid Plans for the period ended March 1953 (which follows) and requested that, because the report was not prepared in time for circulation prior to the meeting, the Councilors review it at their own leisure. Doctor Dessloch advised that a comprehensive report would be prepared for Council consideration at its July meeting.

Quarterly Report of Commission on Prepaid Plans—January–March 1953

This report is in summary, with financial information included. During the period covered by this report there have been two meetings of the Claims Committee, and one each of the Executive Committee, Enrollment and Underwriting, Physician and Public Relations, and Research and Development Committees.

The entire Commission on Prepaid Plans met on March 28–29, 1953.

The following actions have been taken and are now (or soon to be) in effect:

a. By rider, at extra cost, *surgical benefits*, including anesthesia and radiology, available to the newborn beginning with the *first day*. Without the rider, surgical, anesthesia, and radiology benefits are not available until the fourteenth day.

b. *Medical care* in *in-hospital* cases may be purchased, at extra cost and through special rider, so as to be coextensive with the Blue Cross period of hospitalization benefits. The Blue Cross comprehensive contract provides 70 days of hospital care and, if the subscriber so desires, he can therefore purchase an additional 40 days of medical care so as to have these benefits while hospitalized. Blue Cross sells a special 120-day contract, now limited to certain risks. In those cases the subscriber can also purchase an additional 90 days of in-hospital medical care.

c. A *physicians' manual* is in progress and should be available for distribution by fall.

d. A *community enrollment* on an individual or family basis will be developed in three or more locations during 1953 in an effort to extend Blue Shield-Blue Cross to those individuals not otherwise eligible through group purchase.

e. A comprehensive *advertising program* has been scheduled to include all daily newspapers in the state, 70 weeklies, and 21 radio stations. This will be a joint program with Blue Cross and the total cost to the Blue Shield–Blue Cross plans will be approximately $67,000.

f. A new *Physicians Service Report* has been approved and will be in circulation in June.

g. By rider and at additional cost, *increased benefits* may be purchased by a "class" of employees within a group, such as the executives, in multiples of 25 per cent over the "A" schedule, up to "A" plus 100 per cent—*without* full payment. Direct payment to *participating* physicians will be retained.

Catastrophic Insurance

It seems fundamentally desirable that Blue Shield provide a form of catastrophic insurance providing services over and above those available within the standard Blue Shield–Blue Cross programs. The Commission has authorized the early development of this program and has instructed that it be cleared in detail with the Council and by the Commission before it is publicly announced. It is hoped that action may be taken this summer.

There are many other projects in process which will be reported at a later date.

Sales and Statistics

Enrollment in the new program has progressed to a satisfactory extent and it appears that except for a few stragglers the old program will actually be out of existence by July 1.

Utilization appears to be increasing, but trends cannot be determined based upon a single quarter, or even as much as a year's experience. However, in 1949 and 1950, incurred utilization—*i. e.*, claims for services performed during the period for which a premium was paid—averaged 73 per cent. In 1951 it increased to 74 per cent and in 1952 to approximately 78 per cent.

Accounting

Following are comparative statements of income and expenditures for the years 1951 and 1952; balance sheet of December 31, 1952; comparative statement for the periods January 1 to February 28, 1952 and 1953; balance sheet of February 28, 1953.

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES

For the periods January 1 to December 31, 1951 and 1952

	1-1-1951 to 12-31-1951	1-1-1952 to 12-31-1952	Increase or (Decrease)
Income			
Earned Premium Income	$2,132,749.77	$2,656,352.72	$523,602.95
Investment Income	6,747.08	12,640.00	5,892.92
Total Income	$2,139,496.85	$2,668,992.72	$529,495.87
Expenditures			
Physicians' Claims	$1,562,394.92	$2,061,340.95	$498,946.03
Expenses of Agent	192,489.30	259,317.36	66,828.06
Salaries	48,955.75	85,203.51	36,247.76
Legal Expense	5,592.63	8,502.49	2,909.86
Auditing Expense	5,580.22	9,275.50	3,695.28
Actuarial Expense	1,178.99	8,613.34	7,434.35
Conference Expense	4,038.79	10,785.94	6,747.15
Staff Travel	2,240.08	3,456.61	1,216.53
Stationery and Supplies	4,769.84	7,980.87	3,211.03
I.B.M. Expenses	----------	2,056.99	2,056.99
Rent	3,657.00	6,804.00	3,147.00
Office Expenses	1,628.64	2,430.49	801.85
Postage and Express	3,456.76	4,194.93	738.17
Payroll Taxes	1,319.22	1,947.76	628.54
Telephone and Telegraph	3,564.83	5,529.23	1,964.40
Employees Group Insurance	672.60	1,143.80	471.20
Depreciation	992.73	1,552.58	559.85
Insurance	428.01	478.73	50.72
Association Dues	2,715.54	3,100.42	384.88
Other Administrative Expenses	390.19	398.27	8.08
Total Expenditures	$1,846,066.04	$2,484,113.77	$638,047.73
Available for Reserves	$ 293,430.81	$ 184,878.95	($108,551.86)
Disposition of Income Dollar			
Physicians' Claims	$ .73	$ .77	$ .04
Expenses of Agent	.09	.10	.01
Other Administrative Expenses	.04	.06	.02
Addition to Service Benefit Reserve	.09	.05	(.04)
Addition to Administrative Reserve	.05	.02	(.03)
Addition to Investment Reserve	----------	----------	----------
	$ 1.00	$ 1.00	$----------

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

BALANCE SHEET
December 31, 1952

Assets		
Cash on Hand and in Banks		$ 536,758.21
Cash on Deposit with Agent		121,000.00
Due from Agent		161,632.09
Refunds Receivable		1,961.00
U. S. Government Bonds—Net	$797,817.96	
Accrued Interest Income	429.18	798,247.14
Office Furniture and Fixtures—Net		14,487.92
Unexpired Insurance		407.94
Other Deferred Expense		512.71
Total Assets		$1,635,007.01
Liabilities and Reserves		
Accounts Payable		$ 2,342.51
Accrued Expenses		2,881.65
Physicians' Claims Payable		386,415.78
Unearned Income		304,045.81
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—Maternity Benefits	$170,300.00	
Disaster Claims	138,665.00	
Unforeseen Contingencies	364,094.69	
Administrative	216,536.15	
Investment	20,725.42	910,321.26
Total Liabilities and Reserves		$1,635,007.01

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

BALANCE SHEET
February 28, 1953

Assets		
Cash on Hand and in Banks		$ 652,444.09
Cash on Deposit with Agent		124,000.00
Due from Agent		138,537.68
Refunds Receivable		1,535.00
U. S. Government Bonds—Net	$797,945.88	
Accrued Interest Income	2,037.52	799,983.40
Office Furniture and Fixtures—Net		14,245.97
Unexpired Insurance		325.68
Other Deferred Expense		727.71
Total Assets		$1,731,799.53
Liabilities and Reserves		
Accounts Payable		$ 1,883.60
Accrued Expenses		4,883.30
Physicians' Claims Payable		455,978.28
Unearned Income		301,448.02
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—Maternity Benefits	$177,000.00	
Disaster Claims	148,544.00	
Unforeseen Contingencies	352,642.57	
Administrative	237,958.08	
Investment	22,461.68	938,606.33
Total Liabilities and Reserves		$1,731,799.53

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES

For the periods January 1 to February 28, 1952 and 1953

	1-1-52 to 2-28-52	1-1-53 to 2-28-53	Increase or (Decrease)
Income			
Earned Premium Income	$387,875.59	$602,360.52	$214,484.93
Investment Income	1,608.34	1,608.34	
Total Income	$389,483.93	$603,968.86	$214,484.93
Expenditures			
Physicians' Claims	$311,170.50	$488,808.75	$177,638.25
Expenses of Agent	38,147.47	58,250.03	20,102.56
Salaries	10,287.57	17,481.15	7,193.58
Legal Expense	1,303.41	1,048.56	(254.85)
Auditing Expense	284.25	262.50	(21.75)
Actuarial Expense	1,275.18	925.54	(349.64)
Conference Expense	1,032.82	856.98	(175.84)
Staff Travel	313.70	524.49	210.79
Stationery and Supplies	1,098.75	1,248.80	150.05
I.B.M. Expenses		1,109.41	1,109.41
Rent	1,134.00	1,650.00	516.00
Office Expenses	402.83	566.54	163.71
Postage and Express	552.53	581.96	29.43
Payroll Taxes	288.05	577.04	288.99
Telephone and Telegraph	590.07	703.01	112.94
Employees Group Insurance	131.60	254.55	122.95
Depreciation	211.31	300.95	89.64
Insurance	62.46	82.26	19.80
Association Dues	487.67	563.06	75.39
Other Administrative Expenses	5.57	(111.79)	(117.36)
Total Expenditures	$368,779.74	$575,683.79	$206,904.05
Available for Reserves	$ 20,704.19	$ 28,285.07	$ 7,580.88
Disposition of Income Dollar			
Physicians' Claims	$ .80	$ .81	$ .01
Expenses of Agent	.10	.10	
Other Administrative Expenses	.05	.05	
Addition to Service Benefit Reserve	.02	.01	(.01)
Addition to Administrative Reserve	.03	.03	
Addition to Investment Reserve			
	$ 1.00	$ 1.00	$

Conclusion

The Executive and Blue Cross Committees of the Commission met with the Blue Cross Executive Committee during March, without agenda; another meeting has been scheduled for June.

A comprehensive report on Commission activities will be prepared and submitted to the Council for consideration at its July meeting.

14. Wisconsin Society of Pathologists

A resolution of the Wisconsin Society of Pathologists, respecting re-employment of physician-members who are called into the armed forces, was held over from the February–March meeting, and presented as follows:

WHEREAS, under the provisions of Public Law 779, 81st Congress (Doctors' Draft Law), members of the Wisconsin Society of Pathologists and/or of the Section on Pathology of the State of Wisconsin Medical Society may be called to duty with the U. S. Armed Forces, and

WHEREAS, these physicians may be associated with institutions under conditions in which the re-employment provisions of the Universal Military Training Act as governed by U. S. Code Title 50, Section 459, may not be operative, and

WHEREAS, the loss of such association, by the physician upon return from Armed Forces service through the employment of a second physician by the institution during such period of service, would be unfair to the physician, now therefore be it

RESOLVED, that the members of the Wisconsin Society of Pathologists and/or the Section on Pathology of the State of Wisconsin Medical Society pledge jointly and to each other:

(a) To respect the temporarily vacant position of a fellow member on military leave of absence, and

(b) To jointly provide such professional service as may be required by the institution during such period of absence;

And be it further resolved that this resolution be forwarded with a recommendation for parallel action to the organized radiologists and physiatrists in the State of Wisconsin and to the State of Wisconsin Medical Sociey for approval and publication.

Passed by the Wisconsin Society of Pathologists and the Section on Pathology of the State of Wisconsin Medical Society—November 29, 1952.

The society had requested general Council approval of the resolution prior to its circulation, and on motion of Doctors Heidner–McCarey, carried, such approval was given.

15. Physicians Appointed To Blue Cross Membership

In accordance with Section 180.32 of the Wisconsin Statutes, under which Associated Hospital Service, Inc., operates, the physicians and surgeons who are appointed to membership in that organization are subject to the approval of the State Medical Society of Wisconsin.

The following physicians have been added to the corporate membersip of Blue Cross and their names submitted for approval:

L. J. Keenan, M. D., Fond du Lac
Donald G. Dieter, M. D., Madison
M. K. Mookerjee, M. D., Milwaukee
W. A. Wagner, M. D., Oshkosh
Harry Mannis, M. D., Sparta
Donald F. Jarvis, M. D., Tomahawk
C. E. Kampine, M. D., Marathon

On motion of Doctors Kasten–Hemmingsen, carried, the above appointments were approved.

16. Adjournment

The meeting adjourned at noon, Sunday, May 24, 1953.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M. D.
Chairman of the Council

BOUGHT ANY NEW MEDICAL BOOKS LATELY?

Your older volumes would be gratefully received by the physicians, hospitals, and universities of Israel. Especially needed are books in the following categories, published since 1940:

All Medical Specialties
Anatomy
Aviation Medicine
Bacteriology
Biochemistry
Biology
Chemistry
Dentistry
Endocrinology
First Aid
General Practice
Gynecology and Obstetrics
Hospitals
Industrial Medicine
Internal Medicine
Medical Dictionaries
Mental Hygiene
Military and Naval Medicine
Nursing
Nutrition
Pathology
Personal Hygiene
Pharmacology
Physical Medicine
Physiology
Psychiatry
Psychology
Psychosomatic Medicine
Public Health
Surgery
Veterinary Medicine

If you can spare books on any of these subjects, please send them by prepaid parcel post to:

Books for Israel, 115 King Street, New York 1, N. Y.

Note: Up to 70 pounds may be sent by parcel post, at 8¢ for the first pound and 4¢ for each additional pound, marked "Book Rate." Please give return address of individual or organization, so that your gift may be acknowledged. Funds for shipment from New York to Israel have been provided under Point IV, U. S. State Department, sponsors of this project.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 OCTOBER 1953 Number 10

COUNCIL ON SCIENTIFIC WORK

J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
L. G. Kindschi—Monroe
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Marinette
R. E. Garrison—Wisconsin Rapids
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
J. C. Griffith—Milwaukee
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. DOROTHY P. REINHARDT, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madisen
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'— 1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

How Much Will It Cost?*

This question runs like a silver or a golden thread through the tapestry of life. Mothers ask inquiring children a thousand times before they, in turn, place the query at school or the corner store. Teenagers suffer through the cost problem with their clothes and home-made cars, dates and college careers. Adults exist under this financial cloud through life, in every field of activity—church, home, business, social affairs, and death and taxes.

In the past in medicine the subject of "How much will it cost?" was ignored. If the subject was discussed, it was shoved into the front office, and out of the sanctum sanctorum of the physician's "ivory tower." Money was de trop; the costs of certain phases of medical and surgical care were arrived at by some mysterious process known only to the profession itself, or were mailed to patients the first of the month on decorous white forms reading "for services rendered" with a single amount appearing.

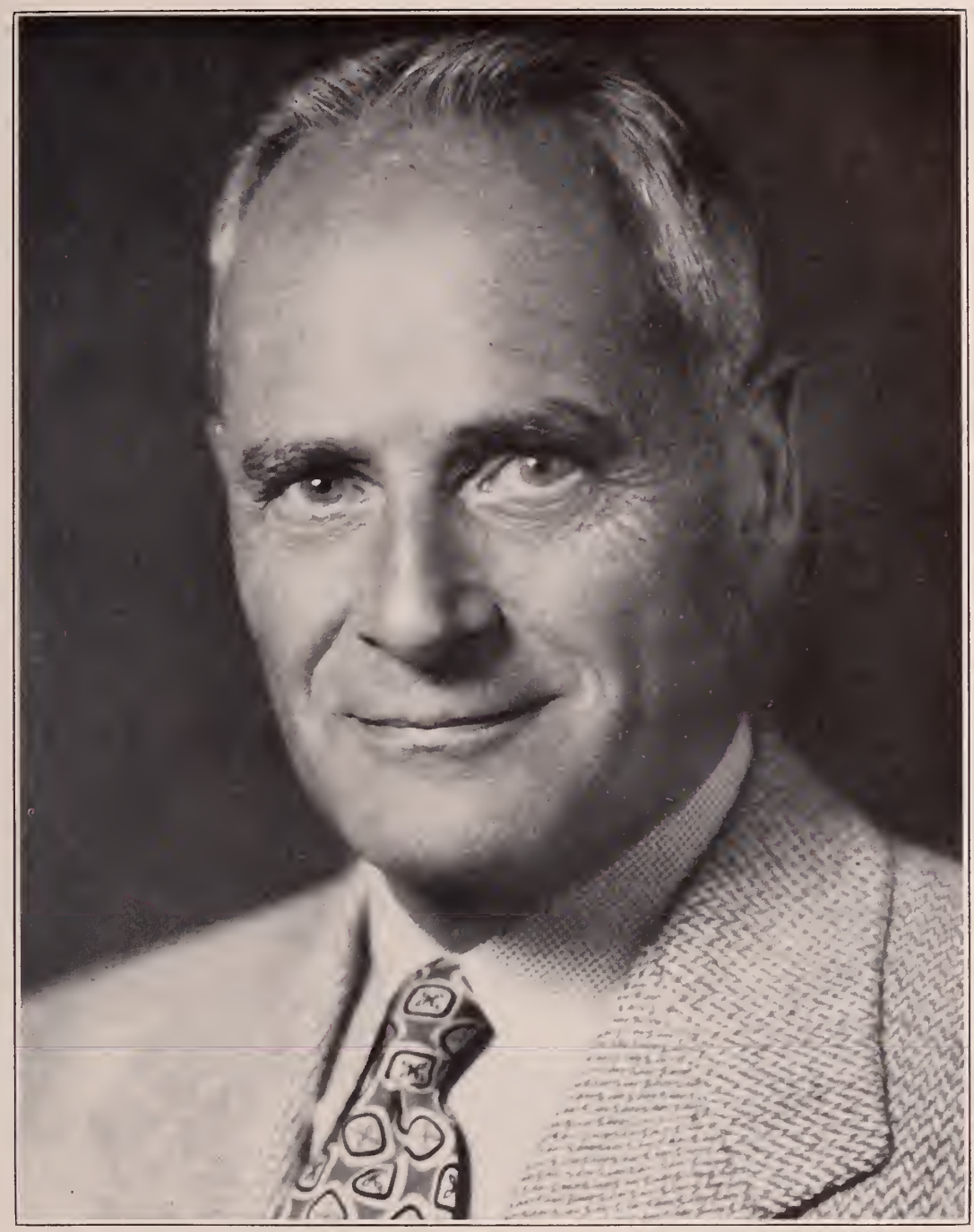
Now frankness with fees is the order of the day. Itemized statements are satisfying patients throughout the country. Costs are being explained, and methods of payment worked out between the patient and his physician. The sensible patient will ask, "How much will this cost me?" There are others who require a gentle push—both patients and physicians—into a discussion of the financial aspects of a medical or surgical situation.

County societies develop an approximate fee schedule which pertains to office and home calls, and outlines the general financial structure under which all physicians work in a given area. A wise and ethical physician will not deviate too greatly from this skeleton structure of good public relations. This implies that he will practice neither exorbitant nor cut-rate medicine. This implies that he will discuss costs and methods of payment and render itemized statements of the work he has done. This implies that he will take time to talk over problems other than those purely medical.

There is only one type of medical practice where this responsibility can be avoided—an entirely socialized form of medicine where "cost is no object" and is not a subject for discussion between the physician and the patient, but a continuous worry for the physician, the patient, and their government.

For good physician-patient relationships, for good medical practice, and for good public relations, discuss the financial problems of each of your patients as he comes to you, so that the mental hazard of uncertainty can be removed and the hurdle of "How much will it cost?" passed before it has an opportunity to grow into a block of misunderstanding or cast a shadow of doubt.

* Reprinted from the August 1953 Secretary's News-Letter of the Illinois State Medical Society.



Dr. H. Kent Tenney, new president of the State Medical Society, was born in Chicago on May 11, 1892. A 1919 graduate of Northwestern University Medical School, Doctor Tenney and his wife, the former Jeanette Walker of Chicago, moved shortly thereafter to Madison, where he worked in the student health department of the University for several years. He has been engaged in the practice of pediatrics since 1926 and is now a clinical professor of pediatrics at the University of Wisconsin Medical School.

Active in organized medicine, Doctor Tenney has served as president of the Dane County Medical Society, chairman of the American Academy of Pediatrics and Wisconsin director of its 1946 Child Health Survey, chairman of a technical committee to study the State Board of Health, and medical consultant for the Bureau of Handicapped Children of the State Department of Public Instruction. In the State Medical Society he has been Dane County delegate to the House of Delegates, Councilor from the Third District, and Speaker of the House. Doctor Tenney is well known in professional and maternal circles as the author of an informal and informative book on child care, "Let's Talk about Your Baby," and as a frequent speaker on the emotional and physical well-being of children.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Doctors for Fluoridation

Some of the ridiculous talk in Wisconsin about fluoridation of municipal water supplies should be silenced by the overwhelming endorsement given to fluoridation by the doctors of Milwaukee.

Milwaukee has been having a terrific struggle on this question. While this might be regarded as strictly the business of the people of Milwaukee, there is another angle. Milwaukee is Wisconsin's largest center of population. The fluoridation program has been proceeding in other cities, including Racine, for several years, but Milwaukee provided a critical test. Acceptance or rejection of a program there would be bound to have a major effect on the rest of the state.

Unfortunately, the issue in Milwaukee was complicated by the presence of some of the world's largest breweries. . . . Reaction among them ran from caution to outright opposition. The fight was carried to the voters . . . and in a referendum last spring they favored protecting their children's teeth in this manner. . . . Milwaukee Aldermen . . . finally ordered fluoridation . . . with the proviso that the Milwaukee County Medical Society be polled.

. . . By a 10 to 1 majority, those polled said they favored fluoridation. . . .

Racine . . . is always in danger of the same type of irresponsible campaign that has been made against fluoridation elsewhere, and we are glad to have the evidence of the Milwaukee medical men to meet any such attacks in the future.—RACINE JOURNAL-TIMES, Sept. 2, 1953.

Paying for Medical Insurance

Much of the continuing debate over plans for more comprehensive voluntary health insurance for Americans of ordinary income revolves around the question of ability to pay for it. Can such Americans, sharing cost through insurance plans, afford protection against the great expense of a prolonged illness or a series of major operations, and of extending that protection into periods of unemployment and old age? . . .

If as good a job were done in selling comprehensive health insurance coverage as is done in selling beer, cigarettes, home permanents and television sets, most Americans in ordinary circumstances would find the ability to pay.—MILWAUKEE JOURNAL, Sept. 5, 1953.

Question for the AMA

The United Press carried a story from Tacoma, Wash., the other day of a desperate offer on the part of the mother and father of a little boy suffering from leukemia to sell an eye apiece to raise cash to provide medical care for the youngster.

Keeping their little 8-year-old boy alive has taken everything the parents had. Doctor bills and medicine had cost more than $5,000 in a little more than a year. . . .

We wonder if such incidents are of any interest at all to those hard-shelled tories in the American Medical Association who have spent millions in propaganda and politics to kill off any and all suggestions for a system of medical care that would be of some help in such cases.—MADISON CAPITAL TIMES, Aug. 21, 1953.

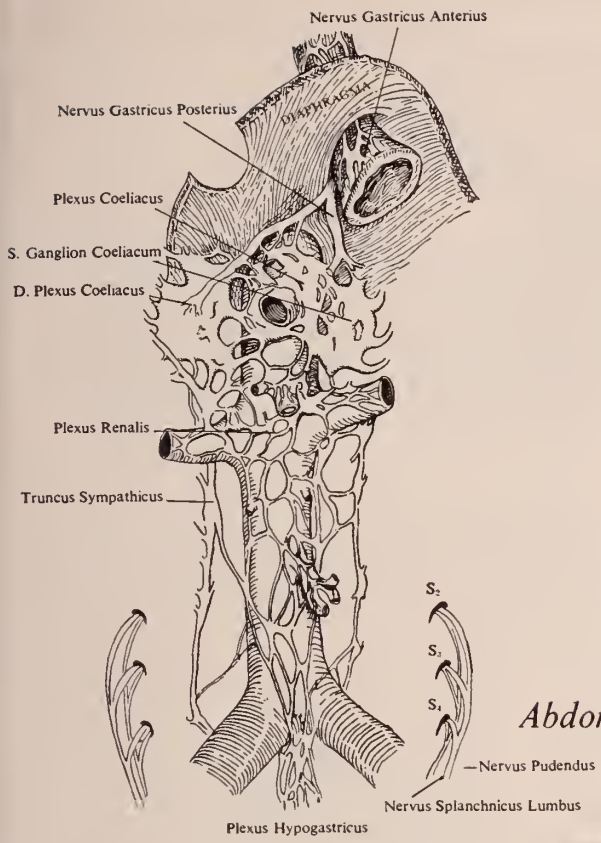
Unnecessary Calls

Every once in a while complaint is heard that the doctor of today is much more reluctant than his predecessor to make house calls.

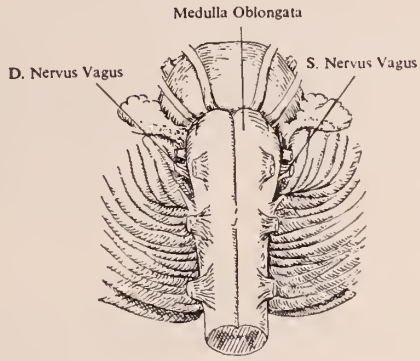
If such is the case . . . perhaps the reluctance is due in large part because so many of the house calls a doctor makes turn out to be unnecessary.

Three Decatur, Ill., doctors made a two and one-half year study of 1,000 consecutive residence visits made by them. They found that in one fourth of the cases a house call is unwarranted because the patient is able to visit the doctor's office. . . .

The doctor is hardly to be blamed for being hesitant to tear himself away from a waiting room full of impatient patients or to roll out of bed in the middle of the night to answer house calls only to find in many cases that the call was unnecessary.—WAUSAU DAILY RECORD-HERALD, Sept. 2, 1953.



Central origin of the vagus nerves (parasympathetic)



Abdominal autonomic plexus (sympathetic)

Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthīne®

"The need[1] for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

Banthīne[2] "has dual effectiveness; it inhibits acetylcholine liberated at the postganglionic parasympathetic nerve endings and it blocks acetylcholine transmission through autonomic ganglia."

It has been shown[1] to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthīne® (brand of methantheline bromide) is supplied in: Banthīne ampuls, 50 mg.—Banthīne tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthīne) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

SEARLE Research in the Service of Medicine

Prescribe Journal-advertised products and you prescribe the best.

Society Proceedings

Brown–Kewaunee–Door

The first fall meeting of the Brown–Kewaunee–Door County Medical Society was held in Kewaunee on September 10. Speaker of the evening was Mr. Robert Murphy, legal counsel for the State Medical Society, who discussed medico-legal relationships.

Price–Taylor

A meeting of the Price–Taylor Medical Society was held at the Medford City Hall on August 22, 1953. The group heard two papers: "Urology in General Practice," presented by Dr. Timothy H. McDonnell; and "New Treatment for Pyschoneuroses" by *Dr. Arthur J. Macht.* Both physicians are associated with the Marshfield Clinic.

Discussants for the program were *Drs. E. B. Elvis, J. J. Leahy, W. W. Meyer, J. L. Murphy, L. E. Nystrum,* and *J. L. Rens.* During the business session of the meeting, the group voted to sponsor Diabetes Detection Week.

Winnebago

Members of the Winnebago County Medical Society and their wives heard a talk by Dr. John Gilroy on "Safety in Handling Flammable Gases" at the regular meeting of the group held on September 10. Doctor Gilroy's speech followed a dinner at the Menasha Hotel.

News Items and Personals

Plans for New Clinic Announced

The community of Tomahawk can look forward to having a modern medical clinic staffed by three physicians in the near future, according to a recent announcement by *Dr. Donald F. Jarvis.* Land has already been purchased for the construction of the new building, and on July 1 Dr. Harold G. Adams joined Doctor Jarvis and his brother, *Dr. Edward C. Jarvis,* to become the third member of the clinic staff. At present the doctors work in their remodeled quarters over the Koth Hardware Store in Tomahawk.

The three physicians are graduates of the Marquette University School of Medicine. Dr. Donald Jarvis has practiced in Tomahawk for three years. His brother joined him in 1952 after a 21-month tour of duty as a flight surgeon with the United States Air Force. Doctor Adams recently completed his internship at St. Joseph's Hospital, Milwaukee.

Dr. D. V. Moen Has Associate

Dr. D. V. Moen of Shell Lake has been joined in practice by Dr. Donald J. Welter of Milwaukee. On July 1, at the completion of his medical studies in Milwaukee, Doctor Welter began his work in Shell Lake.

Waupun Clinic Adds Doctor

Drs. H. H. Hull and *C. P. Reslock* have been joined at the Waupun Clinic by Dr. Jack A. Peterson. Doctor Peterson began his work at Waupun on July 1, at the completion of his internship at St. Mary's Hospital in Madison. He is a graduate of the University of Wisconsin Medical School.

Doctor Klocker Opens Part-Time Burlington Office

Dr. Karl J. Klocker, Chicago physician and surgeon, has opened an office in Burlington and will maintain it on a part-time basis while he continues his practice in Chicago. A graduate of Rush Medical College, Doctor Klocker has practiced in Chicago continuously since 1935, with the exception of a period with the armed forces in World War II. He is an associate member of the surgical staff of Chicago's Mercy Hospital, where he served his internship, and is a clinical instructor of surgery at Loyola University.

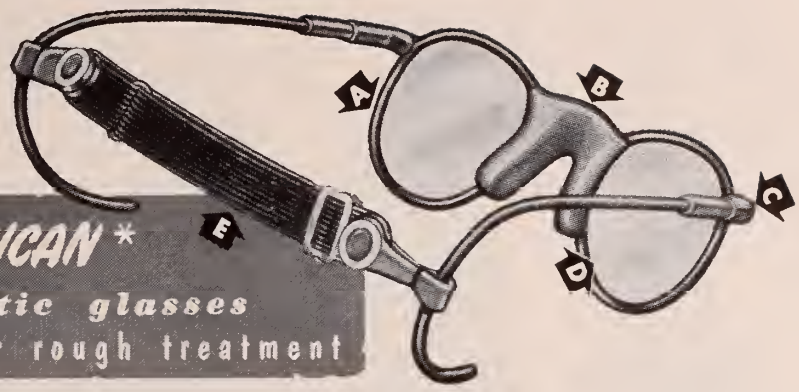
Two New Doctors at Gundersen Clinic

The staff of the Gundersen Clinic and Lutheran Hospital in La Crosse has two new members, Drs. Harry F. Burich and Rowland W. Leiby, Jr., who joined the group in August.

Doctor Burich, who will specialize in general and thoracic surgery, is a 1947 graduate of the University of Minnesota Medical School and interned at Minneapolis General Hospital. During four years as a resident at the Minneapolis Veterans Administration Hospital, he received graduate training in his specialty under the direction of the University of Minnesota.

A specialist in obstetrics and gynecology, Doctor Leiby graduated from the University of Rochester

The completely new . . .



ALL AMERICAN*
athletic glasses
designed for rough treatment

A. EXTRA STURDY ALL-METAL FRAME
B. "CUSHION FIT" SHOCK ABSORBENT RUBBER NOSE PIECE
C. ENDS COVERED TO PROTECT OTHER PLAYERS
D. SAFETY PRESCRIPTION LENSES WITH HIGH BASE CURVE
E. EXPANSIBLE, ADJUSTABLE "GLASS GARD"* HEADBAND

- One Price for All Prescriptions up to and Including 7 Diopters—Case Included
- Order Complete Sample Available at Nominal Cost or Write for Further Information

*Pat. Pend.

Since 1913 Benson OPTICAL COMPANY

EXECUTIVE OFFICES • MINNEAPOLIS, MINNESOTA

Complete Laboratories Serving Wisconsin: Beloit, Eau Claire, La Crosse, Stevens Point, Superior, Wausau, and Duluth, Minn.

SHOREWOOD
HOSPITAL • SANITARIUM
MILWAUKEE, WISCONSIN

2316 E. Edgewood Avenue

Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

Prescription Perfect

RED LABEL • BLACK LABEL

Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.

Born 1820 . . . still going strong

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

(N. Y.) School of Medicine in 1942 and received advanced training in his specialty during a six-year residency at Strong Memorial Hospital and Genesee Hospital in Rochester. For the past year he was engaged in private practice in Rochester and also served as instructor in obstetrics and gynecology at the medical school.

Doctor Houlton Joins Cumberland Clinic

Dr. William H. Houlton, a native of Elk River, Minn., has joined the staff of the Cumberland Clinic. A graduate of the University of Minnesota Medical School, Doctor Houlton interned at Minneapolis General Hospital and at St. Mary's Hospital in Duluth.

Denmark Clinic Adds Associate

Dr. G. V. Hering of the Denmark Clinic has been joined in practice by Dr. Warren L. Bergwall, formerly of Indianapolis. Doctor Bergwall is a graduate of the Indiana University School of Medicine. He served with the Air Corps during World War II.

Dr. J. D. Brown to Practice in Sparta

Dr. Jack D. Brown, formerly of Milwaukee, has joined the Sparta Clinic as a replacement for Dr. R. P. Froeschle, who left the clinic recently to start a practice near his home in North Dakota.

Doctor Brown is a graduate of Marquette University School of Medicine. On completing the Mayo Clinic school of physical therapy, he served his internship at St. Joseph's Hospital in Milwaukee. He has 33 months of naval service to his credit, having served in the South Pacific as a lieutenant junior grade aboard a gasoline tanker.

West Bend Has New Ophthalmologist

On October 1, *Dr. Wallace E. Scheunemann*, formerly of Thiensville, opened an office in West Bend. He will limit his practice to the treatment of the eye. The doctor received part of his medical education at Northwestern University Medical School and was graduated from Marquette University School of Medicine in 1950. He served his residency in ophthalmology at Milwaukee County General Hospital.

R. A. Turcott Replaces E. A. Schoenecker

On August 1, *Dr. R. A. Turcott* took over the duties of health officer of Lake Mills. Doctor Turcott replaces *Dr. E. A. Schoenecker*, who resigned the post because of the pressure of outside duties.

Dr. P. H. Marty Joins Dr. E. V. Hicks

On the completion of a year's internship at the University of Oklahoma Hospital in Oklahoma City,

Dr. Philipp H. Marty has become associated with *Dr. E. V. Hicks*. The new partners will have offices in both New Glarus and Belleville.

Doctor Marty, a native of New Glarus, received his M. D. degree from the University of Wisconsin in 1952. A veteran of World War II, he served over three years in this country and in India.

Chicago Doctor Moves to Eagle River

The Eagle River area has a new physician, Dr. A. J. Pace of Chicago, who has been associated with St. Mary's of Nazareth Hospital in Chicago for 25 years. Not a stranger to Eagle River, Doctor Pace spent around two years there as a physician serving C. C. C. camps in the area.

Doctor Kuglitsch Joins Krohn Clinic

A new member of the Krohn Clinic in Black River Falls since July 25 is Dr. Ervin Kuglitsch, who was formerly associated with St. Joseph's Hospital in Marshfield. Doctor Kuglitsch, a graduate of Marquette, took his internship at St. Joseph's.

New Pathologist at St. Nicholas

On August 1, St. Nicholas Hospital in Sheboygan engaged its first full-time pathologist when Dr. Hobart R. Wood joined the staff. Recently discharged from the Army Medical Corps after two years as chief of laboratory service at the U. S. Army Hospital at Camp Atterbury, Ind., Doctor Wood succeeds *Dr. John L. Ford* of Green Bay, who has been serving as part-time pathologist at the hospital.

A 1944 graduate of Marquette University School of Medicine, Doctor Wood interned at Pierce County Hospital, Tacoma, Wash., and at Milwaukee's Columbia Hospital. From 1946 to 1950 he was associated with the Bender Hygienic Laboratories in Albany, N. Y., first as resident in pathology and, during his last year there, as assistant director of the laboratories. Before entering military service in 1951, Doctor Wood served for a year as director of laboratories at Missouri Baptist Hospital in St. Louis.

Doctor Wood is a member of the American College of Pathologists and is certified by the American Board of Pathology in pathology and pathologic anatomy.

Doctors Fechtner and Hoessel Begin Practice Together

After six years of practice in Mosinee, *Dr. Arthur W. Hoessel* has joined *Dr. H. H. Fechtner* in the general practice of medicine and surgery in Wausau. A 1943 graduate of the University of Wisconsin Medical School, Doctor Hoessel interned at Milwaukee Hospital. He is a member of the staffs of St. Mary's and Memorial Hospitals in Wausau.

PORTABLE OXYGEN . . .

constantly at your service

You now can have oxygen available whenever you need it for medical emergencies in your office or on calls. A portable "Q" cylinder of "Linde" Oxygen U.S.P. plus a clinical regulator and mask will help you cope with anoxia without delay.

A "Q" cylinder contains enough oxygen for about five hours use. Keep a "Q" and a regulator in your office; take it along on calls for emergency use.

available from any of these distributors of

Linde
OXYGEN U.S.P.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding and Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS
LITER FLOW ADAPTORS • OXYGEN THERAPY ADMINISTERING EQUIPMENT

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

Doctor Kuehn Reports for Service

Dr. A. E. Kuehn, practicing physician in Viroqua for around 20 years, reported to the Brooke Army Medical Center, San Antonio, Texas, on September 8 for a tour of duty with the Army. He will hold the rank of lieutenant colonel.

Doctor Oldfield Takes Associate

Dr. R. A. A. Oldfield, Eagle River physician, has been joined in practice by Dr. Edward J. Beil, who was formerly associated with St. Joseph's Hospital in Marshfield. Doctor Beil moved to Eagle River on July 1.

Doctor and Mrs. Coon Feted

The Walworth Congregational Church was the site of an afternoon and evening reception on August 28 in honor of *Dr. W. W. Coon,* Walworth physician, and Mrs. Coon. A double celebration, the party marked the couple's 40th wedding anniversary and the doctor's completion of 25 years of service to the Walworth community.

Doctor Pavelsek Moves to Portage

After three years of practice in Cambria, *Dr. Joseph W. Pavelsek* has joined the staff of the Portage Clinic. A graduate of the University of Wisconsin Medical School, Doctor Pavelsek specializes in internal medicine and diseases of the heart and chest.

D. J. Freeman Joins Father

On the completion of a year's internship at Cincinnati General Hospital, Dr. D. J. Freeman has returned to his home in Wausau to become associated in practice with his father, *Dr. J. M. Freeman,* and *Dr. T. C. Burr.* The young Doctor Freeman was graduated from the University of Wisconsin Medical School in 1952.

Dr. H. A. Ziel Joins Sheboygan Clinic

Dr. Hermann A. Ziel, Jr., a native of Pittsburgh, Pa., became a member of the Sheboygan Clinic on August 1. For the past two years Doctor Ziel has been serving with the Army Medical Corps as chief of the obstetrics and gynecology section at Ft. Devens (Mass.) Army Hospital.

A 1946 graduate of the University of Pittsburgh School of Medicine, Doctor Ziel served a year's internship at St. Francis Hospital in Pittsburgh. From 1947 to 1948 he was assistant resident in obstetrics and gynecology at Altman Hospital in Canton, Ohio.

Doctor Koch Has Associate in Colby

Dr. Raymond Hansen, a native of Camp Douglas, has become associated with *Dr. J. W. Koch* at the

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

SENILE

For further information—
Director, Summit Hospital
Oconomowoc, Wisconsin

For over 70 years...

One Wing of the Lodge

We invite your inquiry

Specialists in the Treatment of Alcoholic Addiction

Treatment of the "problem drinker" is more than a sobering-up process; it is a rehabilitative procedure which must be tailored to the needs of the individual.

Years of intensive research and specialized clinical experience enable us to follow through in all phases of modern restorative treatment—gradual withdrawal, physical rehabilitation, re-orientation and re-education.

You may refer female as well as male patients—we are also equipped to care for narcotic or barbiturate addiction. Moderate rates; treatment period sometimes shortened to just two weeks.

Registered by the American Medical Assn.
Member of the American Hospital Assn.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Colby Clinic. A graduate of the University of Wisconsin Medical School, Doctor Hansen served his internship at St. Joseph's Hospital in Marshfield.

Horswills Settle in Cadott

Drs. C. E. Zenner and *B. J. Haines* of the Cadott Medical Center have been joined by Dr. and Mrs. C. Weir Horswill, lately of Toledo, Ohio. Doctor Horswill will work with the two physicians in the practice of medicine and surgery, and his wife will serve as the staff's medical technologist.

Both natives of Madison, the Horswills graduated from Madison high schools and the University of Wisconsin. Doctor Horswill received his degree from the Medical School in 1952. Before moving to Cadott, the couple worked at the Toledo Hospital, where Doctor Horswill completed his internship and Mrs. Horswill had charge of the blood bank and serology laboratory.

F. P. Nause Returns to Sheboygan

After four years of advanced training in general and chest surgery at Wisconsin General Hospital, *Dr. Frederick P. Nause* has returned to his home town of Sheboygan to enter the private practice of medicine. A 1945 graduate of the University of Wisconsin Medical School, Doctor Nause served a year's internship at the City Hospital in Cleveland, Ohio. On completing two years in the Army Medical Corps as a general surgeon, he took a post as house physician at Sheboygan Memorial Hospital before starting his work at Wisconsin General.

Dr. C. R. Montz Joins Marshfield Clinic

The Marshfield Clinic has a new obstetrician and gynecologist, Dr. C. R. Montz of Lowden, Iowa. A 1948 graduate of the State University of Iowa College of Medicine in Iowa City, Doctor Montz served his year's internship as a member of the Army Medical Corps. During his second year with the Army, he served as a physician overseas.

On his discharge, he began a three-year residency in his specialty at the University of Iowa Hospital. Finishing this spring, he spent two months working with his father, a general practitioner in Lowden, before coming to Marshfield.

Dr. H. C. Evans Associated with Dr. J. E. Albrecht

Dr. Harry C. Evans, a native of Genesee Depot, has joined *Dr. James E. Albrecht* in the general practice of medicine, surgery, and anesthesiology in Jackson.

Doctor Evans is a graduate of the University of Wisconsin Medical School and served his internship at the hospital of the University of Oregon Medical School in Portland. He has taken postgraduate training in infertility at Chicago and the University of Oregon.

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

Make Sure They'll Own It

Your family has a vital stake in their home. To them it means security. But complete ownership is necessary if mother is to have a chance to keep the family together.

The surest way to guarantee home ownership is to secure one of our low-cost mortgage-cancellation policies. In fact, adequate life insurance coverage will release funds for better living and the enjoyment of more pleasure today. And the peace of mind that comes from owning enough life insurance to cover fundamental needs will actually make you a better provider.

Consult our representative today. No obligation.

Wisconsin Life Insurance Co.

30 W. Mifflin St. Madison, Wis.

Medical Directors Named by Kimberly–Clark

Dr. Gordon W. Petersen of Neenah has been named to the newly created post of full-time medical director of the Kimberly–Clark Corporation. Associated with the company for 14 years, Doctor Petersen has been superintendent of its sanitary products development in the research and development laboratories. In his new position he will work closely with *Dr. J. B. MacLaren* of Appleton, who becomes associate director after 29 years as the corporation's medical consultant and the last six years as its part-time medical director.

Dr. L. V. Kempton Returns from Service

After four months as a first lieutenant at Omsted Air Force Base, Middleton, Pa., Dr. Leo V. Kempton has resumed his practice at the Burlington Clinic. Doctor Kempton was recalled into service in May under the provisions of the doctor draft law and released under the new provisions of the law passed on June 1.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. M. J. Donkle Has Associate

Dr. Eugene S. Hartlaub has become associated with *Dr. Milton J. Donkle* of Janesville in the general practice of medicine. A native of Chicago, Doctor Hartlaub graduated from Loyola University School of Medicine and completed a year's internship at Janesville's Mercy Hospital on July 1.

Janesville Father and Son Join in General Practice

Dr. O. V. Overton of Janesville has recently been joined in practice by his son, Dr. Richard S. Overton. A graduate of the University of Wisconsin Medical School, the younger Doctor Overton has just completed a year's internship at Mercy Hospital.

Dr. D. W. Springer Moves to Monroe

At the completion of a three-year residency at Hines (Ill.) Veterans Administration Hospital, Dr. Donald W. Springer has become associated in practice with *Drs. David D. Ruehlman, C. Earl Baumle,* and *John M. Irvin* of Monroe. Doctor Springer's specialty is general and thoracic surgery.

A 1945 graduate of Loyola University School of Medicine, Chicago, Doctor Springer served a rotating internship at Cook County Hospital for one year before entering military service. On his release from the air force in 1948, he accepted a year's residency at Ohio Valley Hospital, Steubenville, Ohio.

Doctor Sorensen Joins Dells Clinic

Late in July Dr. E. T. Sorensen became a member of the staff of the Dells Clinic in Wisconsin Dells. Just finished with a year's internship at Memorial Hospital in South Bend, Ind., Doctor Sorensen graduated from the University of Wisconsin Medical School in June 1952. He is a native of Racine.

Dr. G. J. Derus Opens Office

On August 17 Dr. Gerald J. Derus, a 1952 graduate of the University of Wisconsin Medical School, opened an office in Madison for the general practice of medicine. Between the completion of a year's internship at Madison's St. Mary's Hospital and the opening of his office, Doctor Derus substituted for *Dr. E. J. Nelson* of Sun Prairie while the latter was on vacation.

Dr. S. P. Vinograd Opens Madison Office

Dr. S. P. Vinograd has announced the opening of an office for the practice of internal medicine in Madison. A 1946 graduate of the University of Wisconsin Medical School and a veteran of two years' service as a Navy doctor, Doctor Vinogard served his internship at Tauro Infirmary in New Orleans and a three-year residency in internal medicine at St. Mary's Hospital in Madison.

Dr. G. J. Maloof Takes Associate

Dr. Edmund R. Liebl, a 1952 graduate of the University of Wisconsin Medical School, has joined *Dr. George J. Maloof* of Madison in the general practice of medicine and surgery. Doctor Liebl served his internship at Cleveland (Ohio) City Hospital.

Eye Specialist Begins Practice

Since September 1 Madison has had a new ophthalmologist, *Dr. John A. Buesseler*, who graduated from the University of Wisconsin Medical School in 1944. Recently released from service with the air force, Doctor Buesseler interned at Cleveland (Ohio) City Hospital and took postgraduate work in ophthalmology at Harvard, the Massachusetts Eye and Ear Infirmary, and the University of Pennsylvania. From 1948 to 1951 he worked as resident physician in ophthalmology at the University of Pennsylvania Hospital, held a fellowship in his specialty at Philadelphia Children's Hospital, and was a visiting fellow with the Philadelphia Skin and Cancer Hospital.

J. A. BUESSELER

NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY
525 Holly Avenue, Madison 5, Wisconsin

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2-1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6-5303

Doctor Coon Named to AHA Board

At the 55th convention of the American Hospital Association, held in San Francisco in early September, *Dr. Harold M. Coon* of Madison was elected a member of the organization's board of trustees. Doctor Coon, a graduate of the University of Pennsylvania School of Medicine, is superintendent of Wisconsin General Hospital and the Wisconsin Orthopedic Hospital for Children in Madison and serves as professor of hospital administration and executive secretary of the University of Wisconsin Medical School.

Doctor Hopkins Returns to Dean Clinic

Recently released from service with the Navy Medical Corps, *Dr. C. E. Hopkins* has resumed his practice of pediatrics at the Dean Clinic in Madison. Doctor Hopkins has been associated with the clinic since February 1952.

Proctologist Opens Madison Office

An office for the treatment of diseases of the rectum and colon has been opened in Madison by *Dr. Gordon V. Marlow*. A native of Madison, Doctor Marlow graduated from the University of Wisconsin Medical School and took postgraduate training in proctology at the University of Minnesota Medical School and the clinics of Ancker Hospital in St. Paul. For the past two years he has been a clinical instructor in the department of surgery at Minnesota and an assistant in the proctology clinic of Ancker Hospital.

Doctor Hartenstein Takes Teaching Post

Dr. Hans Hartenstein, formerly of Milwaukee, has moved to Syracuse, N. Y., to take a position as instructor in the department of pediatrics at Syracuse University College of Medicine. On June 1 Doctor Hartenstein was released from the Army Medical Corps, having served in Japan and Okinawa as a pediatrician.

SOCIETY RECORDS

New Members

J. H. Huston, 1824 Church Street, Wauwatosa.

T. C. Burr, Jr., 506½ Third Street, Wausau.

A. B. Fidler, 231 West Wisconsin Avenue, Milwaukee.

B. K. Smith, 502 Third Street, Wausau.

G. V. Marlow, 110 East Main Street, Madison.

D. R. Notbohm, 411 Madison Avenue, Fort Atkinson.

Changes in Address

D. E. Olson,* Madison, to O. M. S. Fitzsimons Army Hospital, Denver, Colorado.

M. S. Tverberg,* Mauston, to U. S. Disciplinary Barracks Dispensary, Camp Crowder, Missouri.

R. W. Cranston, Platteville, to Tioga Clinic, Tioga, North Dakota.

V. E. McNeilus, Wild Rose, to West Salem.

J. J. Haugh,* Randolph A.F.B., Texas, to 307th Bomb Wing, A. P. O. 239–1, % Postmaster, San Francisco, California.

E. G. Barnet, Wisconsin Rapids, to 1011 Professional Building, Phoenix, Arizona.

D. B. Becker, Jr..* New York, to U. S. Army Hospital, Fort Belvoir, Virginia.

G. E. Carroll, Laona, to 952 Baltimore Street, Mobile, Alabama.

R. C. Mathewson, New Orleans, Louisiana, to P. O. Box 236, Whitfield, Mississippi.

T. C. Lipscomb,* San Antonio, Texas, to U.S.A. Hospital 2151–1, Aberdeen Pr. Gr., Maryland.

R. J. Krill, Philadelphia, Pennsylvania, to 3200 North 36th Street, Milwaukee.

R. G. Mendez, Chicago, Illinois, to 1936 North Bartlett Avenue, Milwaukee.

H. R. Duffy,* Pensacola, Florida, to First Marine Air Wing, % Fleet Postoffice, San Francisco, California.

F. P. Nause, Madison, to 927 North Eighth Street, Sheboygan.

Norman Cameron, Madison, to Department of Psychiatry, Yale University, School of Medicine, 333 Cedar Street, New Haven 11, Connecticut.

R. R. Liebenow,* Fort Sam Houston, Texas, to 8019 Army Unit, A.P.O. 547, Unit 3, % Postmaster, San Francisco, California.

J. M. Usow, Milwaukee, to 213 South Arnez Drive, Beverly Hills, California.

J. R. Evrard, Camp Breckenridge, Kentucky, to 208 East Wisconsin Avenue, Milwaukee.

Tukuso Taniguchi,* Seattle, Washington, to Fort Lewis, Fort Lewis, Washington.

O. H. Stokke,* Milwaukee, to 3345 Medical Group, Chanute Air Force Base, Illinois.

T. C. Sweeney,* Beloit, to 126 South Elliott Street, Williamsville 21, New York.

R. P. Froeschle, Sparta, to Box 53A, Tioga, North Dakota.

W. H. Lohr,* Ft. Lawton, Washington, to 865 Second Street, Lebanon, Oregon.

Hans Hartenstein, Milwaukee, to 818 Westcott Street, Syracuse 10, New York.

*Military Service.

MARRIAGES

Dr. James Clark McCullough, Fond du Lac, to Miss Maryjean Erickson, San Francisco, August 29.

DEATHS

Dr. James S. Reeve, retired Appleton physician. died on July 22. Born in Groveland, Massachusetts, in 1864, he would have been 89 years old on August 23. He was the son of Dr. J. T. Reeve, who was

secretary of the State Medical Society for 19 years and who also served as Society president in 1875.

A graduate of Lawrence College in Appleton, where his family settled after the Civil War, Doctor Reeve studied medicine at Johns Hopkins, Harvard Medical School, and Columbia, receiving his degree from the latter in 1889. In 1891, after completing his internship at Methodist Hospital in Brooklyn, he started his practice in Appleton. With one interruption for a year of further medical study in Vienna and Berlin he practiced there continuously until his retirement at the age of 70.

Active in civic affairs, Doctor Reeve was president of the Appleton Civic League and a charter member and once secretary of the board of directors of the Appleton Public Library. For 45 years a member of the board of trustees of Lawrence College, he performed the duties of secretary of the board for 25 years and was considered the person best informed on the history and traditions of the college.

Doctor Reeve was a member of the Outagamie County Medical Society, of which he once served as president; a member and for several years secretary of the Fox River Valley Medical Society; and a member of the State Medical Society and the American Medical Association. At one time he was president of the staff of St. Elizabeth Hospital in Appleton. In 1948 he was granted the honor of life membership in the State Medical Society.

He is survived by his wife, Alfreda; and their twin daughters, Mary, New Orleans, and Edith, San Francisco.

Dr. Frederick P. Purdy, 61, died on July 27 after an extended illness. He was born in Columbus, Ohio, on June 15, 1892.

A graduate of Baylor University College of Medicine, Doctor Purdy practiced in Mukwonago for 27 years until ill health forced his retirement seven years ago. He was a member of the staff at Waukesha Memorial Hospital.

Survivors include the doctor's wife, Bessie; a son, Willis; and a daughter, Jean, all of Mukwonago.

Dr. Wayne A. Munn, widely known Janesville physician and surgeon, died at his home on August 8. Born near Belvidere, Illinois, on December 9, 1881, he was 71 at the time of his death.

Doctor Munn was a 1906 graduate of Northwestern University Medical School. After completing a year's internship at St. Luke's Hospital in Denver, he began his practice in Janesville on September 4, 1907, a practice that was interrupted only once—for service with the medical corps during World War I—in the 46 years until his death. On his return from military service, Doctor Munn joined the late Dr. F. B. Farnsworth to found the Munn-Farnsworth Clinic, now known as the Munn-Koch Clinic.

A well-known breeder of Guernsey cattle and Shetland ponies, Doctor Munn was one of the

ROEMERS—MILWAUKEE

Surgical Supplies
Hospital Supplies
Office Furniture
Laboratory Supplies

* * *

Complete Service to the Medical Profession

* * *

Roemer Drug Company
606 No. Broadway
Milwaukee 2, Wisconsin

Distributors to the profession
of fine
Injectable Vitamins and Endocrines

Interstate Pharmacal Company
P. O. Box 252 Beloit, Wis.
MAIL ORDERS SHIPPED IMMEDIATELY

DOERFLINGER ARTIFICIAL LIMB CO.
Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

founders of the Rock County Breeders Association and served as president of both the National Guernsey Association and the National Shetland Pony Association.

Active in medical circles, Doctor Munn was a charter member of the Wisconsin State Surgical Society, chief of staff of Mercy Hospital for several years, a preceptor of the University of Wisconsin Medical School for 20 years, and surgical instructor of the school of nursing of Mercy Hospital. In addition to his membership in the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, he was a fellow of the American College of Surgeons and a member of the American Association of Railroad Surgeons.

He is survived by his wife.

Dr. J. Elmer Twohig, practicing physician in Fond du Lac for 40 years, died on August 14 at the age of 66. He had been in ill health for about a year.

Doctor Twohig was born in the town of Osceola, Fond du Lac County, on February 18, 1887. On his graduation from Marquette University School of Medicine in 1913 he studied with a Chicago specialist in internal medicine for eight months and then entered partnership with two of his brothers, Dr. D. J. Twohig, Sr., and the late Dr. H. E. Twohig. Joined by other physicians, the brothers established the Fond du Lac Clinic.

Doctor Twohig was a member of the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association.

His wife and twin daughters survive him.

Dr. Paul R. Currer, Milwaukee physician, died on August 22 at the age of 36.

A native of Milwaukee, Doctor Currer received his medical degree from Marquette University School of Medicine in December 1942. Before entering military service in August 1943, he interned at Milwaukee County General Hospital. In February 1946 he was discharged from the Army Medical Corps with the rank of captain and returned to Milwaukee to enter practice with his father, the late Dr. Paul M. Currer. Since his father's death three years ago, he had been engaged in solo practice.

Doctor Currer was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include the doctor's wife, Janet; a son, David; and a daughter, Jean.

Dr. Albert F. Young, retired Milwaukee physician, died on August 24. Born in Wooster, Ohio, on December 19, 1869, he was 83 at the time of his death.

Doctor Young was graduated from Rush Medical College, Chicago, in 1894. Shortly thereafter, he came to Milwaukee as first assistant physician at the county general hospital. In 1896 the Milwaukee County Board appointed him county physician to care for the sick of Milwaukee's east side, the county jail, and the central police station. He was also alienist for the district court, a post which often required him to testify as an expert witness at murder trials.

In 1916 Doctor Young was appointed superintendent of the Milwaukee County Hospital for the Insane. During his 22 years in this position he made many improvements, including the change of the hospital's name to the County Hospital for Mental Diseases, the abandonment of strait jackets, and the institution of occupational therapy and social service departments.

For many years Doctor Young was an assistant professor of psychiatry at Marquette University School of Medicine. On his retirement from his hospital and teaching posts in 1939, Marquette appointed him assistant professor emeritus.

A former president of the Milwaukee Neuropsychiatric Society, Doctor Young was a life member of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving are his wife, Lillian; a son, Willard A., Wauwatosa; and a daughter, Mrs. Harold Chatland, Missoula, Montana.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 **Milwaukee, Wis.**

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clyboum St. **Milwaukee 3, Wisconsin**

CORRESPONDENCE

F. GREGORY CONNELL, M. D.
Oshkosh, Wisconsin

To the Editor:

Pollard's article in the June *Journal* prompts the following comments.

It is interesting to find that despite constant study two of our frequent everyday clinical problems, hyperchlorhydria and hypertension, remain unsolved, and that surgical treatment in both cases consists of attacks upon the autonomic nervous system by vagotomy for one and sympathectomy for the other. They are rarely combined clinically. Hyperchlorhydria, as in uncomplicated duodenal ulcer, is usually associated with *hypo*tension.

It is noteworthy because of propinquity, if for no other reason, to find articles dealing with these two unsolved clinical problems in the current literature—Paul Banzet ("Vagotomy in the Treatment of Peptic Ulcer," Postgraduate Medicine, June 1953, p. 491) and Marvin Pollard ("Therapy Not to Employ in the Treatment of Peptic Ulcer," Wisconsin M. J., June 1953).

Vagotomy has passed through many vicissitudes and conflicts of opinion, since Dragstedt in 1946 recommended it in treatment for peptic ulcer. The approach was at first thoracic, later abdominal. The indication at first was for all peptic ulcers, then not for gastric, later not for duodenal, and now only for stomal ulcer. Vagotomy was used alone at first and later with simple gastroenterostomy or with partial (distal) gastrectomy.

At one time, gastroenterostomy was the generally accepted CURE for peptic ulcer. At the Mayo Clinic in 1931 it was performed in 80 per cent and in 1950 in only 10 per cent of operated cases (90 per cent distal gastrectomy). If it took so many years to learn that gastroenterostomy was not a CURE for peptic ulcer, one is prompted to ask: How long will it take to learn that partial (distal) gastrectomy, the presently accepted surgical treatment, is likewise not a cure for peptic ulcer?

"In science the important thing is to modify and change one's ideas as science advances." (Claude Bernard: Introduction à l'étude de la médecine expérimentale, 1865.) Stimulation to secretion may continue by auxiliary routes (detours, as it were) such as that observed by Grey (J.A.M.A., Dec. 15, 1951), or by some other as yet obscure compensatory mechanism, like muscular hypertrophy in the motor system or collateral circulation in the vascular system. With longer postoperative follow-ups one finds an ever-increasing trend toward a return to the "status quo ante." As an example of the prodigality with which the human organism is supplied with alternative measures to take the place of functions which may be temporarily or permanently put out of action, gastric secretion is stimulated not only by neural but also by humoral, chemical, and mechanical influence. Compensatory adaptation to constantly changing internal and external environment is life itself.

The surgical treatment of duodenal ulcer has always been and still is dynamic, not static, with future improvements in prospect. After clinical trial, with longer follow-ups, vagotomy seems to be losing popularity. If vagotomy, to be successful, must be combined with gastroenterostomy, one cannot help wondering if the short-term favorable influence may not be due to the gastroenterostomy rather than to the vagotomy.

All of which prompts the query: If vagotomy cures duodenal ulcer, isn't it logical to assume that sympathectomy should cause duodenal ulcer? In 1,498 sympathectomies Pollard found only 13 cases of peptic ulcer. (How many ulcers were present before the sympathectomy is undetermined.) In 5 of these cases there developed serious acute emergencies, all *without* premonitory symptoms.

From these reports and similar observations, it would seem that sympathectomy does not *cause* peptic ulcer. Therefore one might be inclined to think that vagotomy does not, itself, *cure* peptic ulcer.

Yours truly,
/s/ GREGORY CONNELL

MARQUETTE UNIVERSITY
Milwaukee 3, Wisconsin

Dear Sir:

I want you to know that I am most grateful to you for your kindness in sending to me a gift subscription for *Today's Health* through 1953. Be sure that I appreciate this courtesy very much.

I should like to take this occasion also to thank you and your associates in the State Medical Society for the great help which you are giving our Medical School in its work here at Marquette. We all deeply appreciate your good interest in the school and are grateful for the assistance which you give it.

With kindest regards and best wishes for the continued success of the great work which you are doing, I am

Yours very sincerely,
/s/ E. J. O'DONNELL, S. J.
President

THE STATE OF WISCONSIN
Board of Health

Dear Sir:

As President of the State Board of Health, and in its behalf, I would like to express our apprecia-

HURLEY X-RAY COMPANY

Distributors for:

Picker X-Ray Corporation
Equipment—Supplies—Accessories

Burdick Corporation
Direct Writing Electrocardiographs
Physical Therapy Equipment

Ille Electric Corporation
Whirlpool—Paraffin Baths

Eastman—DuPont—Ansco
Films—Chemicals—Screens

For your requirements call or write

HURLEY X-RAY COMPANY
2511 W. Vliet St. Milwaukee 5, Wis.

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899.

specialized service assures "*know-how*"

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 6-1021

tion for the splendid way in which all functions connected with the dedication of the new Laboratory of Hygiene were conducted. We want to extend our sincere thanks to you, the members of the Staff, and the State Medical Society for everything in connection with the event. The members of the Board are particularly happy over the privilege of having lunch with the Council and the opportunity of attending the Testimonial Dinner for Dr. Stovall.

Sincerely yours,
/s/ S. E. Gavin, M. D.
President

Dr. Homer W. Carter
1023 Regent Street
Madison 5, Wisconsin

Dear Sir:

In regard to the recent Clinical Program at Lake Lawn, Delavan, Wisconsin, I wish to express my humble appreciation of the most excellent program that you, Roy, and Dr. Joseph Gale put on for us.

To my mind, the speakers were—in toto—the best and they presented their messages of "up-to-date work" in a most usable and stimulating manner. Of course, I haven't attended the former meetings this winter, but I have been to some of the previous ones.

There should have been 100 to 150 instead of 50 M. D.'s there.

Sincerely
/s/ Homer M. Carter, M. D.

The State of Wisconsin
Department of Nurses

Dear Sir:

You will recall that in 1952 I asked your organization to assist in financing a recruitment project which the State Department of Nurses had agreed to undertake, but because recruitment was not mentioned in the law the Department of Budget & Accounts was not willing to authorize the expenditure of funds.

These nursing notebooks have been in the high schools for one year, and as you know from the excerpts sent to you last fall, they are sincerely appreciated and are being used. I thought that you would be interested in knowing that we are continuing to assume responsibility for keeping these notebooks up to date.

In July, with the splendid assistance of the Auxiliary to the State Medical Society of Wisconsin, we were able to assemble and package the newest materials. These will be sent to the high schools of the state with directions for incorporating them in the notebook the latter part of September.

Thank you again for your assistance in this recruitment project.

Very truly yours,
/s/ Adele G. Stahl, R. N.
Director

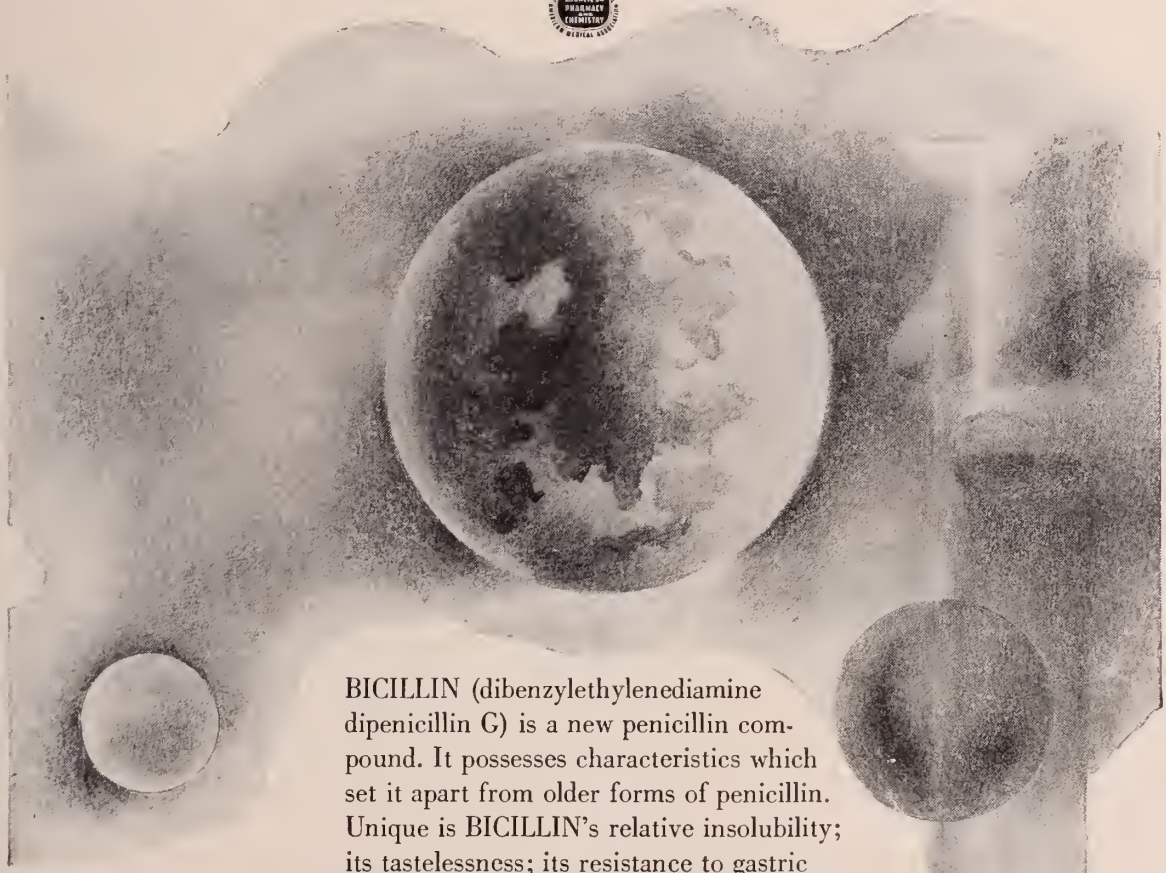
New Horizons in Antibiotic Therapy

BICILLIN®

Dibenzylethylenediamine Dipenicillin G

A NEW FORM OF PENICILLIN

***NOW*... Council Accepted**



BICILLIN (dibenzylethylenediamine dipenicillin G) is a new penicillin compound. It possesses characteristics which set it apart from older forms of penicillin. Unique is BICILLIN's relative insolubility; its tastelessness; its resistance to gastric degradation; the apparent ease with which patients tolerate it; the stability of its oral forms. BICILLIN indeed opens to view new horizons in antibiotic therapy . . . new applications of penicillin—drug of choice in a wide range of infections.

BICILLIN is available in oral suspension, tablet and injectable forms

Wyeth Philadelphia 2, Pa.

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
FINNEY MANSFIELD DIVISION

535 North Dearborn Street, Chicago 10, Illinois

ICAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

OCTOBER 1953

For TV Audiences . . .

Earmarked "for local medical societies only," the American Medical Association offers four top-notch new television shows to be used *exclusively* by state and county medical societies to spark their public relations programs. These films were designed for airing on public service time over local TV stations; they will not be aired on any national TV network.

Each program deals with a different popular medical subject: (1) "Operation Herbert"—a fast-moving humorous play discussing medical care costs, stars well-known actor Jackie Kelk; (2) "A Citizen Participates"—documentary-type story tells about a town that needs a doctor and how one citizen heads a campaign to get one; (3) "What to Do"—series of six five-minute shows with ABC women's commentator Nancy Craig showing how to use a thermometer, apply artificial respiration, and stock a medicine chest, and demonstrating the emergency treatment of colds, abdominal pains, and headaches; and (4) "Your Doctor"—Louis de Rochemont film now available *for first time* on TV, describes medical training facilities today and focuses on career of a GP in a rural mountain community.

Prints of these new filmed TV shows may be obtained by writing to the AMA's TV Film Library, 535 North Dearborn Street, Chicago 10, Ill. Be sure to book these shows well in advance of schedule date.

Medicine Strikes at "Big Game"

What medicine is doing to overcome the principal causes of death in the world today is the theme of a new series of radio transcriptions to be released by the AMA September 15. The 13-program series—"Medicine Fights the Killers"—covers the following subjects: coronary thrombosis, rheumatic heart disease, lung cancer, leukemia, hypertension, accidents, nephritis, premature births, tuberculosis, pneumonia, diabetes, suicide, and poliomyelitis. Prepared by the Bureau of Health Education, these transcriptions may be aired over local radio stations under the auspices of state and county medical societies.

PR Conference in St. Louis

The AMA's sixth annual National Medical Public Relations Conference will be held Monday, November 30—the day before the opening of the Clinical Session—at the Jefferson Hotel, St. Louis. The Conference program will be geared primarily for physicians. Members of the House of Delegates, officers of state and county medical societies, officers of the Association, and executive secretaries and PR personnel are cordially invited.

Plan Now for St. Louis!

Singing the "old St. Louis blues" again . . physicians and AMA staff members are completing arrangements for the seventh annual Clinical Session December 1 to 4 in St. Louis. This year's program has been designed to give the general practitioner an opportunity to see and hear the latest developments in medicine. A brief glance at the scientific program indicates that some outstanding features have been lined up to cover the newest techniques in medical practice. Special features include *fracture* demonstrations; *problems of delivery*, manikin demonstrations by leading obstetricians; *traffic accidents*, an exhibit symposium combining the experiences of physicians, the National Safety Council, and police departments, and stressing the responsibility of the physician in the prevention of such accidents; and *diabetes*, which includes exhibits and question-and-answer conferences in an adjoining room.

The Jefferson Hotel has been selected as the headquarters for House of Delegates sessions and Reference Committee meetings. All other features —Scientific Exhibit, lectures, motion pictures, color television, Technical Exhibit—will be presented at the Kiel Auditorium. More than 80 exhibits, with continuous demonstrations and plenty of time for personal consultation, will make up the Scientific Exhibit. The Technical Exhibit will feature approximately 150 displays covering all types of office and medical practice needs.

Plan now, doctor, to attend this worth-while medical meeting!

Tips for PR-Wise Physicians

From the human to the business side of medical practice is covered in an attractive new public relations manual to be published this fall by the American Medical Association. Containing numerous suggestions offered by physicians from all parts of the country, "Rx Public Relations" gives useful tips on improving doctor-patient relationships and handling business affairs in the doctor's office. This up-to-date booklet will be distributed to all AMA members after September 25.

Report on Grievance Committees

Just off the presses is a detailed report on county medical society grievance committees. Prepared by the AMA's Council on Medical Service, this study deals with the organization, functions, and operations of 198 mediation committees throughout the country. To make the data of more practical value, the societies have been divided into groups according to size. Copies of the booklet are available from the Council.

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Ophthalmic Pathology: An Atlas and Textbook. By Jonas S. Friedenwold, M. D.; Helenor Campbell Wilder; A. Edward Maumenee, M. D.; T. E. Sanders, M. D.; John E. L. Keyes, M. D.; Michael J. Hogan, M. D.; W. C. Owens, M. D.; and Ella A. Owens, M. D. Published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. Philadelphia, W. B. Saunders Company, 1952. Price $18.00.

This is a completely new and modern text which combines the best features of Friedenwald's text, *Pathology of the Eye*, and the *Atlas of Ophthalmic Pathology*, by DeCoursey and Ash, first published by the Army Medical Museum and sponsored by the American Academy of Ophthalmology and Otolarynogology in 1938.

The introductory chapters present the anatomy, physiology, and histology of the normal eye and adnexa in sufficient detail to give the student a working knowledge of the normal before undertaking the study of pathologic changes. These findings in the normal are elaborated upon throughout the text wherever necessary to aid in understanding pathologic changes.

The third chapter deals with the normal growth and aging of the eye and adnexa, and the fourth is directed to an excellent and clear presentation of the present concepts of inflammation and the immune process. The correlation of ocular pathology and general pathology is stressed wherever applicable throughout the text.

The remainder of the book is devoted to the specific pathology of the eye and adnexa, with arrangement of the chapters according to disease entities, insofar as possible; when this is not feasible, the pathology is considered as it involves specific structures. There are excellent chapters on vascular disease and congenital and developmental anomalies.

One noticeable omission is the failure to recognize the more modern concept of the relation of glioma of the optic nerve and chiasm to Recklinghausen's disease, a concept developed at the University of Wisconsin Medical School.

There has been a very real effort made to simplify the often complex ophthalmic terminology, and a morphologic classification has been used whenever a specific etiologic classification is impractical or inaccurate.

Each chapter is profusely illustrated by outstanding photomicrographs from the Armed Forces Institute of Pathology. One could only wish that some of them were in color.

This book fulfills a long-felt need for an up-to-date, simplified, well-illustrated ophthalmic pathology text, and will be welcomed eagerly by practitioners and students alike.—F.J.D.

Standard Values in Blood. Edited by Errett C. Albritton, A. B., M. D.; Fry Professor of Physiology, The George Washington University. Philadelphia, W. B. Saunders Company, 1952.

This is a collection of 101 tables of data recording normal values for physical, chemical, and morphologic aspects of the blood of man and animals. A few of the subjects covered are physical properties, coagulation phenomena, blood groups, erythrocytes, leukocytes, hemoglobin, bone marrow, proteins, lipids, carbohydrates, vitamins, enzymes, electrolytes, gases, and the effects of radiation.

While this volume is a ready reference source of data for the laboratory and research worker, it does not appear to this reviewer to be of interest to the general physician. The extensive bibliography will be helpful to the research worker.—R.F.S.

Living in Balance. By Frank S. Caprio, M. D. Washington, D. C., The Arundel Press, Inc., 1951. Price $3.75.

Dr. Frank Caprio's *Living in Balance* is another book to be added to the already crowded shelf of popularized psychiatric texts. The reviewer finds it difficult to see who will profit from perusing the oversimplified "explanations" given by the author, or who will be startled into normalcy by pondering

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D.
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

THE MARY POGUE SCHOOL

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

Catalogue on request.

G. H. MARQUARDT, M. D.
Medical Director

BARCLAY J. MACGREGOR
Registrar

32 Geneva Road, Wheaton, Ill. (Near Chicago)

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL

(The Pioneer Post-Graduate Medical Institution in America, Organized in 1881)

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both x-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media, such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, peri-renal insufflation and myelography. Discussions covering roentgen departmental management are also included.

For information for these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

such suggestions as "Refuse to become alarmed or frightened by your fears and doubts" or "Remind yourself that we all possess certain instincts which we are obliged to control."

It seems unlikely that the book will do harm, since it contains very little which is either thought-provoking or new. On the other hand it remains to be seen how many people (as the jacket blurb claims) "can now enjoy freedom from tension and worry about domestic and business problems, conflicts of emotion in love affairs and sexual matters" after reading *Living in Balance*.—A.C.W.

Brain Surgeon. The Autobiography of William Sharpe, M. D., Director of Neurosurgery, Manhattan General Hospital, New York City; Consultant in Neurosurgery: Gouverneur Hospital; Jamaica City Hospital; Nassau Hospital (Mineola, L. I.); Vassar Brothers Hospital (Poughkeepsie, N. Y.); Monmouth Memorial Hospital (Long Branch, N. J.); Ann May Hospital (Spring Lake, N. J.). New York, The Viking Press, 1952. Price $3.75.

This colorful autobiography should provide enjoyment and interest for many, many readers. In direct narrative style the author recounts his boyhood as the son of an impoverished clergyman in Philadelphia and elsewhere; his college and medical school years at Harvard furnish the background for many unusual anecdotes told with disarming frankness. His success in earning his way through school will strike many readers as phenomenal. Similarly, the account of a year spent in China reads like fiction, because of his extraordinary experiences in operating on Chinese royalty.

The chapters dealing with his years spent in practice in New York City are illuminating in their comments on medical practices and personalities of the time. The tone of the book becomes progressively more serious as the author recounts his experiences in treating patients with cerebral palsy, hydrocephalus, and head injuries. Since this is a personal narrative the discussion of these subjects is by no means complete nor would there be general agreement with some of his opinions, but in his missionary zeal he highlights many important facts.

Accounts of his trip to Europe where he met both Hitler and Stalin are noted in a rather casual fashion and are quite in keeping with the general theme of the book. The final chapter, "Life Is What You Make It," contains an informal statement of his philosophy of life and of medicine and ends with an outline of what he considers important measures to prevent cerebral palsy. His bibliography includes two books, one on *The Diagnosis and Treatment of Brain Injuries* and another on *Neurosurgery*, in addition to 55 articles in American medical journals and ten in Latin–American publications. There is also a list of references of confirmatory articles and books on intracranial hemorrhage as the cause of cerebral spastic paralysis.

There emerges from this autobiography the picture of a warm, generous, and zealous doctor, a sur-

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

When writing advertisers please mention the Journal.

Under His Foot, the Live Grenade

Technical Sergeant
Robert S. Kennemore, USMC
Medal of Honor

THE MACHINE GUN belonged to E Company, Second Battalion, Seventh Marines. It was under the command of Technical Sergeant Robert Sidney Kennemore.

It was busy. For on this November night fanatical Red masses were swamping Marine defense positions north of Yudam-ni.

Fifteen yards in front of the gun, a Red soldier raised his body briefly and sent a grenade into the air. It landed squarely among the crew. In a split second, Sergeant Kennemore had covered it with his foot.

There was a violent, muffled explosion, but not a man was hurt. Not a man except Sergeant Kennemore. He had given both his legs to save his comrades' lives.

"When I was on active duty," says Sergeant Kennemore, "I sometimes wondered if people back home cared as much about stopping Reds as we did. Now that I'm a civilian, I know they do. And one proof is that so many of my neighbors are investing in E Bonds for our country's defense. Believe me, I know how important that defense is. So I'm investing, too, just as I hope that you are!"

Now E Bonds pay 3%! Now, improved Series E Bonds start paying interest after 6 months. And average 3% interest, compounded semiannually when held to maturity. Also, all *maturing* E Bonds automatically *go on* earning—at the new rate—for 10 *more* years. Today, start investing in U. S. Series E Defense Bonds through the Payroll Savings Plan: you can sign up to save as little as $2.00 a payday if you wish.

Peace is for the strong!
For peace and prosperity save with
U.S. Defense Bonds!

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

geon who was one of the less well-known neurosurgeons of his time, but who has obviously had a full and dramatic life and made worth-while contributions to the profession. The autobiography of Dr. William Sharpe can be recommended for reading by the medical profession, some of whom will enjoy the anecdotes and adventures of his life and others the discussion of serious medical problems, many of which yet remain to be solved.—T.C.E.

Diagnostic Bacteriology. By Isabelle G. Schaub, A. B., technical director, clinical bacteriology laboratories, The Johns Hopkins Hospital; instructor in bacteriology, The Johns Hopkins University School of Medicine and the Nurses Training Schools, The Johns Hopkins Hospital, and Sinai Hospital; and M. Kathleen Foley, M. A.. instructor in bacteriology, department of biological sciences, College of Notre Dame of Maryland, and formerly bacteriologist in charge of the diagnostic bacteriological laboratory of the medical clinic, The John Hopkins Hospital. Fourth edition. St. Louis, The C. V. Mosby Company, 1952. Price $4.50.

The fourth edition of *Diagnostic Bacteriolgy* is up to date and adequate as a guide for the student or worker in a strictly bacteriologic laboratory. Persons not familiar with the previous editions should be notified that syphilis, the animal parasites of man, and the groups and types of human blood are not considered in this work, perhaps because of the tendency toward laboratory specialization.

The increased discussion, explanation, and interpretation make this edition better than the original one for the orientation of the student or worker but, in the opinion of the reviewer, are less effective in this respect than the corresponding sections of the Army technical manual (*Methods for Medical Laboratory Technicians*). Those who have found the previous editions of Schaub and Foley's *Diagnostic Bacteriology* satisfactory, however, should find the fourth edition even more valuable.—F. E. H.

The Medical Clinics of North America. Tulane–Toronto Number. Philadelphia and London, W. B. Saunders Company, 1952.

This volume is composed of a well-organized series of short and concise articles which constitute symposia on the elicitation and interpretation of various common symptoms and on the psychologic aspects of medicine. In addition, more comprehensive discussions of the diagnostic and therapeutic aspects of asthma, obesity, jaundice, colonic amebiasis, chronic Bright's disease, and heart failure are included. Particular emphasis has been placed upon the problems arising in the everyday practice of medicine.

For the most part, the articles present excellent and entirely practical reviews of the subject matter. Especially timely are the lucid and realistic discussions of the relationship of emotions to bodily functions and the frequently encountered emotional disorders. This is probably the most valuable material in the entire volume. Unfortunately, the consideration of psychotherapy is oversimplified and therefore is likely to be misleading to the inexperienced.

The volume will be of especial interest and value to the student and general practitioner.—M. J. M.

Essentials of Dermatology. By Norman Tobias, M. D., Associate Clinical Professor of Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis State Hospital; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology; Visiting Physician in the Department of Dermatology at the St. Louis City Hospital. Fourth Edition. Philadelphia, J. B. Lippincott Company, 1952. Price $6.00.

The fourth edition of this book shows general revision in light of recent advances in therapy, pathology, and etiologic studies. The addition to each chapter of a discussion of the nursing approach to the diseases presented is an excellent idea and one that should be enlarged upon in future editions.

The number of pages devoted to syphilis have been shortened without detracting from the importance that syphilis plays in medicine and dermatology. This has been accomplished in a large measure by shortening the discussion on different drugs used in the treatment of syphilis and devoting more space to one drug, penicillin.

The subject matter is covered in a clear, concise way, making it useful for both physician and student use. There would be less confusion and greater clarity for the student, however, if the various diseases were not sub-classified as to types. For example, acne vulgaris is sub-classified into 10 types and discoid lupus erythematosus into 7 types.

The book is highly recommended to physicians, students, and nurses.—S.A.M.J.

In very special cases
A very superior Brandy

Specify 84 PROOF
★ ★ ★
HENNESSY
THE WORLD'S PREFERRED
COGNAC BRANDY
For a beautifully illustrated book on the story of Hennessy, write—
Schieffelin & Co., Dept. HT, 30 Cooper Square, N.Y. 54

They'd crowd an outdoor cafe...

all the patients who represent the 44 uses for short-acting NEMBUTAL®

44 PATIENTS? Just look in the picture above. You'll find them all. And with every NEMBUTAL patient, with every NEMBUTAL use, these are the facts that you'll find the same:

1. *Short-acting* NEMBUTAL *(Pentobarbital, Abbott) can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.*
2. *The dosage required is small—only about one-half that of many other barbiturates.*
3. *There's less drug to be inactivated, shorter duration of effect, wide margin of safety and little tendency toward morning-after hangover.*
4. *In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.*

3-212A

All are sound enough reasons for your prescription to call for short-acting NEMBUTAL. How many uses have *you* tried? Abbott

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

FOR SALE: 30 ma Continental x-ray and vertical fluoroscope, used, shock proof. Accessories include tank, hand timer, and cassette holder. Address replies to Box 517 in care of the Journal.

FOR SALE: Office equipment and instruments of a recently deceased Wisconsin physician. Address replies to Box 518 in care of the Journal.

FOR SALE, by widow of physician, examination table, office desk, and an assortment of instruments. Address replies to Box 519 in care of the Journal.

OPHTHALMOLOGY LOCATION WANTED: UW graduate, returning to Wisconsin for family and business reasons, wishes association with board member ophthalmologist. Training includes 3-year residency in EENT and basic science course in eye followed by several years of EENT practice. Could give excellent office and surgical assistance. Arrangements of association open. Address replies to Box 508 in care of the Journal.

GENERAL PRACTITIONER BADLY NEEDED in Adams–Friendship. Large practice with little competition. Local incorporated association ready to provide backing. Railroad guarantees at least $2,000 a year. Office and home available and rent free for 3 months. Hospital with ambulance facilities near by. Contact Harold T. Johnson, Adams, Wis.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately. Write Box 505 in care of the Journal.

FOR SALE: Spencer microscope in carrier. Also other physician's instruments. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

MD WANTED for small group operating clinic and 25-bed modern hospital in rural town close to large city in southwest Wisconsin. $12,000 minimum first year, then partnership. Qualifications should include enough surgical experience to cope with accidents and major surgical emergencies. Excellent modern house available. Send details in first letter to Box 506 in care of the Journal.

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WANTED: General practitioner to join two-man group in thriving midwestern Wisconsin college community. Salary guaranteed first year, then partnership; new modern hospital facilities available. Address replies to Box 510 in care of the Journal.

PHYSICIAN-SURGEON WANTED for industrial community serving 3,000 people within a 20-mile area. We will lease attractive doctor's residence and a fully equipped small first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year of practice and should increase each year thereafter. Available for immediate occupancy. Call or write the Goodman Lumber Company, Goodman, Wis.

OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

WANTED: Young, progressive clinic in western Wisconsin needs pediatrician, certified or board qualified, and a general practitioner. Excellent opportunity. Address replies to Box 521 in care of the Journal.

AVAILABLE AT ONCE: Established general practice in small town in west central Wisconsin, heart of the fishing and hunting country. Owner has gone overseas with Army. Ample income from surrounding territory. Small hospital within 12 miles. Completely equipped suite of offices in part of large, newly decorated home with spacious grounds overlooking small lake. Reasonably priced for quick sale. Excellent opportunity for young physician. Address replies to Mrs. G. Mitchell, Merrillan, Wis.

FOR SALE: Practice and fully equipped 15-room office in central Wisconsin college town of 6,000. Gross over $40,000. New open hospital in city. Excellent for 3-man group. Because of health, owner will remain on part-time basis only. Address replies to Box 522 in care of the Journal.

WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

FOR SALE: Office building of late Dr. C. F. Peterson in Independence. Tile veneered, 21 by 46 ft., full basement, oil furnace. Beauty parlor upstairs could be converted into apartment. A few instruments for sale. Records go with instruments. Adddess replies to Box 524 in care of the Journal.

FOR SALE: Mobile 30 ma shockproof x-ray unit. Jones basal metabolism unit in excellent condition. Direct-writing electrocardiograph. Microscopes, new and used. Assorted cassettes with intensifying screens. Surplus x-ray filter grids, never used. FCC-approved short-wave diathermy units. Slightly used film filing cabinet. Write C. C. Remington, 1204 W. Walnut Street, Milwaukee.

INSTITUTIONAL position wanted by woman physician. Well trained in psychiatry, including shock treatments. Wisconsin license. Address replies to Box 525 in care of the Journal.

FOR RENT: Large one-room office suitable for consultant, particularly a psychiatrist, on one-day-a-week basis or full-time if desired. Active community in south central Wisconsin, with drawing population of 50,000. Office in professional building, has private bathroom and walk-in storage closet. Reasonable rental. Address replies to Box 526 in care of the Journal.

FOR SALE: General practice and complete office equipment. Owner retiring, will stay to introduce new physician. Address replies to Box 527 in care of the Journal.

FOR SALE: McCaskey Register System for physicians. Desk model, four drawers. Steel cabinet, 30½ by 17 by 32 inches. Price, $50.00. Address replies to H. G. E. Mallow, M. D., 210 Madison Ave., Fort Atkinson, Wis.

EXCELLENT OFFICE SPACE AVAILABLE for specialist in ENT, internal medicine, or radiology. Largest downtown building in Racine. Reasonable rental. Write or call Alex Wald, 610 W. Wisconsin Ave., Milwaukee, Wis.

WANTED: Registered medical technician. Good working conditions and salary. Write or call the Pippin Clinic, Richland Center, Wis.

FOR SALE to one purchaser: Entire office equipment of deceased general practitioner. Surgical equipment, furniture for 2 offices, 3 filing cabinets, instrument cabinet, new reception room furniture, 2 examining tables, 2 air conditioners, x-ray equipment, darkroom equipment, 2 scales. Address replies to Mrs. Paul Currer, 9405 Ridge Blvd., Wauwatosa 10, Wis. Tel. SPring 4–2686.

FOR SALE: X-ray machine built especially for head work. Darkroom equipment. Stainless steel operating table. 20 years' records of large EENT practice. Now stored in Wisconsin Rapids. Practice unopposed. Any reasonable offer accepted. Write to E. G. Barnet, M. D., 1011 Professional Bldg., Phoenix, Ariz.

HydroCortone®

(HYDROCORTISONE, MERCK)

offers definite therapeutic advantages

1

HYDROCORTONE is a natural and principal anti-inflammatory adrenocortical steroid.

2

HYDROCORTONE Tablets produce the same therapeutic results as cortisone, and *in smaller dosage.*

3

HYDROCORTONE Tablets generally may be administered in a dosage two-thirds that of cortisone.

4

HYDROCORTONE Tablets recently were drastically reduced in price. Cost of therapy now is substantially the same as with cortisone.

Literature on request

Primary Sites of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES, JOINTS, AND BURSAE**—Osteoarthritis; Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's disease; Psoriatic arthritis; Bursitis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Atopic dermatitis; Exfoliative dermatitis; Dermatitis venenata (*e.g.*, poison ivy); Dermatitis medicamentosa. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's disease; Following adrenalectomy for hypertension, Cushing's syndrome, and neoplastic diseases. **10. BLOOD, BONE, AND MARROW**—Allergic purpura; Acute leukemia* (lymphocytic or granulocytic); Chronic lymphatic leukemia.* **11. LYMPH NODES**—Lymphosarcoma;* Hodgkin's disease.* **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Angioneurotic edema; Serum sickness; Sarcoidosis; Drug sensitization; Waterhouse-Friderichsen syndrome.

*Transient beneficial effects.

HYDROCORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of hydrocortisone.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

© Merck & Co., Inc.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- L. J. Kurten, Racine
Delegate ---------- M. A. Hardgrove, Milwaukee
Alternate ---------- R. N. Allin, Madison

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- E. D. Schwade, Milwaukee
Alternate ---------- Harry Tabachnick, Milwaukee
Secretary ---------- A. W. Bryan, Madison

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer - Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Acting Chairman --- George Nadeau, Green Bay
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- N. L. Low, Racine
Vice-Chairman ----- E. H. Pawsat, Fond du Lac
Secretary ---------- S. E. Kohn, Milwaukee
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	6, 7, 41
Audiphone Utilities	27
Ayerst, McKenna & Harrison, Ltd.	14
Baker Laboratories	10
Barr X-Ray Company	30
Benson Optical Company	21
Bergmann Prescription Center	34
Canada Dry	22
Central Drug	34
Coca-Cola Company	4
Cook County Graduate School of Medicine	5
Doerflinger Artificial Limb Co.	29
Endocrine Laboratories	26
General Electric	13
Hotel Schroeder	5
House of Bidwell	27
Hurley X-Ray Company	32
Interstate Pharmacal Company	29
Keeley Institute	25
Kennedy-Mansfield	34
Lakeside Laboratories	12
Lederle Laboratories	facing page 30
Lilly, Eli and Company	18
Linde Air Products	23
Mallard, Incorporated	16
Mallatt Pharmacy	34
Mather Pharmacy	34
Mayer Drug	34
Mead Johnson and Company	47
Medical Protective Company	32
Merck and Company	43
Milwaukee Sanitarium	48
New York Polyclinic	34
Orthopedic Appliance Company	30
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	9
Physicians Casualty Association	38
Pogue, Mary, School	34
Professional Business Service	569
Rennebohm's	34
Roemer Drug Company	29
Rogers Memorial Sanitarium	48
S. and L. Signal Company	27
Sacred Heart Sanitarium	34
St. Croixdale Sanitarium	5
Schering	11
Schieffelin and Company	40
Searle, G. D. and Company	19
Shorewood Hospital Sanitarium	21
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp.	8
Summit Hospital	24
Time Insurance Company	567
Upjohn Company	15
Winthrop-Stearns, Inc.	17
Wisconsin Life Insurance Company	26
Wyeth	33

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

H. KENT TENNEY, Madison, President
A. J. McCAREY, Green Bay, President-Elect
L. O. SIMENSTAD, Osceola, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1956
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
R. E. Garrison__Wisconsin Rapids
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1956
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1954
J. C. Griffith_____Milwaukee
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1955

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
G. E. Forkin, Menasha, 1955

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. F. Boock 119½ Front Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	N. E. Bear Monroe	D. E. Mings Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

* Except June, July, and August.

** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette-Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	D. M. Bailey Gillette	G. R. Sandgren Suring	
Oneida-Vilas	M. J. Donohue Antigo	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce-St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price-Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	R. S. Vivian 405 E. Grand Beloit	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau-Jackson-Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Fourth Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington-Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 NOVEMBER 1953 Number 11

Message to the House of Delegates*

By H. KENT TENNEY, M. D.
Madison

AT THIS time it is customary for the incoming President to discuss what he thinks are the important projects ahead of us. To become familiar with the various activities of the Society, he sits through as many committee meetings as he possibly can during the year.

In that experience I have come to the conclusion that the work of the Society is in excellent hands. The foresight of these committees in meeting the problems that come to them is really very heartening. We need have no worry about the activities of the Society which must be carried out. What I have to say is something that cannot be delegated to a committee, and should not be relegated to the minutes of the previous meeting.

As I sat in those meetings, I became increasingly aware of certain trends—international, national, and local—certain trends of a social and educational nature which are influencing the work that these committees are called upon to do. Some of these social trends, of course, originate from international tensions and anxieties. Some of the activities that we have carried out as a result of these trends are excellent.

For example, our increasing consciousness of our responsibilities toward the mentally retarded child: for many years it was a problem that no one paid any attention to. Now it is receiving considerable thoughtful attention in medical as well as sociologic fields.

We pride ourselves on our educational system—that we require all children to be educated; but we have said that unless a child measures up to a certain somewhat arbitrary standard he can't go to school. And that has been a discriminatory conclusion on our part, a conclusion we are now trying to modify. Our activities on behalf of the mentally retarded child will reflect to our everlasting credit.

But there are some tendencies which I believe are open to some question. As a result of these international tensions and anxieties, we find tensions and anxieties in all strata of society—the sort of feeling, "Let's grab it while we can; we might as well get it, or somebody else will."

This feeling is reflected, for example, in the tendency of labor to ask for more pay and less work. It is reflected also even in our own profession. From time to time we hear criticisms by older doctors that the young fellows don't want to work these days; we hear, for example, about a doctor who wants to join a group but would like to have every third night and every other week end off. That is a manifestation of this same tendency.

Also, the work of the various committees has uncovered situations which seem to imply that we are losing some of the affection that the public formerly had for us. To the attention of the Grievance Committee, for example, come many cases which are the result of misunderstandings between physician and patient. These misunderstandings can usually be ironed out to the satisfaction of both. They do indicate, however, that there is a slow loss of that close contact which formerly existed between the patient and his physician.

This has its educational implications, too, because it is incumbent upon every physician to act as a teacher. Whether you know it or not, whether you like it or not, every physician is a teacher. He must teach his patients to live with their diseases. He must teach good health and diet practices. At present there is a fairly malignant form of food

*Presented before the House of Delegates, One Hundred Twelfth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 5, 1953.

faddism starting up in this state. It is incumbent upon us to educate our patients to the truth about these dietary fads.

It is quite easy for a pediatrician to assume the role of teacher, because more than half of his work is done with normal children, which means that he is educating families in how to take care of children and what children are like.

There is no area of human activity which is devoid of a health concept. Man cannot live without adequate recreation. He must have access to good schools and churches, and his working conditions must be good. So we must think of health not simply as the absence of disease. If we are to understand man's full health environment, we must consider every aspect of man's activity.

We often hear of the professorial physician or the full-time research physician who has retired to his ivory tower, not understanding the problems of the patient or of the practitioner. But what about the private practitioner who retires to his private office and says, "I haven't time to consider your worries about your business or family. You have a gastric ulcer, so just stop worrying"? It would be just as logical for him to say to another patient, "Yes, you have pneumonia, but I haven't time to give you penicillin." Unless a doctor takes into account every aspect of a man's life, he is giving inadequate treatment.

We, the older physicians, must remember that we are also acting continually as teachers to the younger men coming up in medicine. One of the recommendations that you will find in the report of the Grievance Committee makes that statement. If we will constantly remember that the younger men in medicine do need the example of the older men who welcome them into the fraternity of medical men, who will go a little out of their way to give help and guidance and advice to the young men coming along, we will gather stronger and stronger fraternities of medical men.

It does seem that we have lost some of the close contact we formerly had with patients, and some of the affection they had for us. Reluctantly I admit that this is true; but I cannot believe and will never believe that the medical men of today are any less worthy of that kind of affection than our fathers in medicine are said to have been. It is simply a slight breakdown in our relationships with our patients.

That has come about, of course, because of the rapid rise of scientific medicine. It is no longer necessary to have many of the close contacts which used to be necessary to carry out full treatment. Specific medication has made them unnecessary. But with the increasing complexities of life those close contacts are actually more important than they ever were before.

I am not advocating any kind of return to the "good old days"; in fact, I have little patience with the doctrine that says, "Let's go back to the good old days." However, we do have a heritage from the past which is the finest tradition of our profession. We must not lose that heritage.

And we must couple our heritage with the extraordinary advances that have been made in scientific medicine, we must couple all aspects of human endeavor, human relationships, and scientific advancement, to the end that we make the world a better place to live in.

That is what we shall carry on during the coming year, striving to make this world a better place to live in.

CHEST FILM ENLARGEMENTS AVAILABLE

The Wisconsin State Board of Health, in response to a suggestion by the Chest Committee of the State Medical Society, announces that it is prepared to furnish, on request by physicians, copies or enlargements of 70 mm. films taken of their patients in mobile unit surveys throughout the state.

In order to expedite such service the State Board of Health will also serve as a clearing house to locate films taken by other agencies which operate independent units.

Physicians desiring such information or films should communicate with:

Division of Tuberculosis Control
Wisconsin State Board of Health
1 West Wilson Street
Madison 2, Wisconsin

Nasal Hemorrhage

By IRVING MUSKAT, M. D.
Milwaukee

Introduction

NASAL hemorrhage is commonly encountered by the general physician as well as by the rhinologist. It is frequently slight or moderate, and its cause is apparent from a brief history or upon the first examination. When the etiology is not evident at the first examination, or upon its initial control, further study is necessary. When nasal hemorrhage recurs, or when the hemorrhage has been profuse, the patient should be hospitalized for efficient control and diagnosis. In the differential diagnosis, the following causes are considered:

1. Trauma
   - Fingernail picking
   - External trauma
   - Intranasal operations
   - Foreign bodies
   - Blowing nose: Coryza
2. Disturbances of Circulation
   - Hypertension
   - Arteriosclerosis
   - Nephritis
   - Telangiectasis
3. Infectious Diseases
   - Rheumatic fever
   - Rheumatic heart disease
   - Exanthema
   - Coryza
   - Pneumonia
   - Herpes
   - Nasal diphtheria
   - Typhoid fever
   - Paratyphoid fever
4. Blood Dyscrasias
5. Granulomata
   - Tuberculosis
   - Lupus erythematosus
   - Syphilis
     - Congenital
     - Tertiary
6. Neoplasms
   - Benign
   - Malignant
7. Miscellaneous
   - Liver disease
   - Hypoprothrombinemia
   - Metabolic disease
   - Pregnancy
   - Chemical poisons: Cr, Hg, P
   - Salicylism
   - Ozena
   - Nasal polyps

Type of Bleeding

Nasal bleeding usually is slight and stops spontaneously, but it may be so severe as to endanger life. Spar and Hallberg,[1] in a statistical study of severe nasal bleeding, found that except in those cases due to trauma, 40 per cent had either hypertensive disease or arteriosclerosis or both, diagnosed previously, and of those past 60 years old 60 per cent had hypertension. Their studies also showed that in 3 out of 5 patients over 60 years of age bleeding was from the anterior septum, and was so severe as to require hospitalization for its control. Eleven patients required external carotid artery ligation.

In patients with hypertensive vascular disease the initial epistaxis may cease spontaneously with the lowering of the blood pressure, only to recur in a few hours as the pressure rises again. This is a common occurrence. Woodruff[2] believes that nasal hemorrhage associated with hypertension and arteriosclerosis is a distinct entity, and can be differentiated from other causes in the middle-aged and elderly individual by its sudden and severe onset from the nose or into the nasopharynx. Such bleeding often originates from a plexus of vessels in the lateral nasopharyngeal wall under the posterior tip of the inferior turbinate. Through a pharyngoscope these vessels appear quite large and dilated, and indicate phlebosclerosis as well as arteriosclerosis. Four of the 5 cases which demanded external carotid ligation for their control occurred from this plexus. Bleeding in hypertensive disease, however, may occur at any site in the nose.

Besides the general effects from the loss of blood, Bean[3] has shown that coronary occlusion may be precipitated by a sudden fall of blood pressure from epistaxis in patients with coronary disease, while Long[4] has reported loss of vision of varying degrees after repeated nasal hemorrhages.

Profuse bleeding resulting from nasal trauma often requires vessel ligation for its control. The literature is replete with such cases. For example, Barker[5] reports 2 cases of external trauma in which external carotid ligation was performed to control severe nasal hemorrhage after intranasal packing had failed, and in a case reported by Abrahams,[6] external carotid ligation was resorted to after repeated unsuccessful attempts with intranasal packing to control a nasal hemorrhage after an ethmosphenoid operation. Strauss[7] reviews 7 cases of nasal hemorrhage during pregnancy, 3 of which resulted in death, and reports another which was controlled by external carotid artery ligation. Such hemorrhage occurs most often during the sixth or seventh month of pregnancy. When in any case severe bleeding is from the ethmoidal vessels, ligation of the ethmoidal arteries should be performed.

Although epistaxis may occur from any site in the nose, areas like the Kiesselbach-Little area at the lower anterior septum, which contain a rich plexus of vessels, are especially vulnerable to irritation and intravascular pressure. Cody[8] considers drying of the overlying mucous membrane blanket, which exposes the many tiny vessels to slight trauma, an important factor in nasal bleeding. Dohlman[9] believes that besides these factors there are additional unexplained endogenous factors which contribute to the occurrence of bleeding at this area. In this connection I have observed that there is very frequent bleeding from superficial erosions in this area in pulmonary tuberculosis patients, without any history or evidence of recent rhinitis or other nasal pathology.

Methods of Control

The methods of control of nasal hemorrhage depend upon the site, severity, and cause of the bleeding. The physician should proceed in a definite and efficient manner. When bleeding is severe or when the first emergency measures are unsatisfactory, the patient should be immediately hospitalized, where special and exacting procedures can be instituted. Of fundamental importance is the administration of morphine to allay anxiety and shock, and the transfusion of whole blood to replace a massive blood loss. It is well to remember that transfusion has no value in purpura haemorrhagica. These cases are always accompanied by a loss of blood platelets and may be relieved by splenectomy.

The first measure is to remove any inadequate packing and to remove all blood clots by suction or irrigation with boric solution or weak hydrogen peroxide, followed by the rapid insertion of cotton pledgets dipped in hydrogen peroxide, adrenalin-cocaine solution, or other vasoconstricting agents. This maneuver often controls bleeding sufficiently to inspect and attack the bleeding site for permanent control. A valuable instrument for this purpose is a combined suction and desiccating cannula, of which there are several on the market, designed to clear the bleeding area and to apply a desiccating current to the bleeding vessel at the same time. It may be necessary to infract a turbinate or perform a submucous resection of the septum to locate the bleeding vessels. The application of the suction-desiccating cannula saves precious time and loss of blood.

As a substitute for the suction-desiccating cannula, the ordinary electrocautery apparatus may often be used effectively, or electrocoagulation may be accomplished by using a copper applicator to conduct the desiccating current to the bleeding point.

When bleeding is slight and the bleeding point can be defined, chemical cauterizing agents may be used with good results. Of these, 50 to 100 per cent silver nitrate, 50 to 100 per cent trichloroacetic acid, or phenol or chromic acid are commonly used. Instead of these escharotics, the injection of sclerosing solution[10] under the bleeding area after topical anesthesia may be used with good results in cases where bleeding is moderate and where the bleeding area can be reached. Fox[10] reported that repeated epistaxis from varicosities of the Kiesselbach-Little area were usually controlled by one, seldom two, injections of 0.25 to 0.50 cc. of Sylnasol solution into the mucosa just beneath the bleeding point so that a vesicle appears. Asherson[11] injected 0.5 cc. of a 10 per cent phenol in almond oil without untoward aftereffects. As a substitute for sclerosing solutions, I have found that the injection of plain sterile water under the mucoperiosteum at the bleeding site is most satisfactory. Its effect appears to be a pressure obliteration of the bleeding vessel. With these injections, however, it often occurs that the needle puncture produces an additional point of bleeding, so that a pressure tampon must be resorted to, especially when there is increased vascular pressure or increased friability of mucous membrane or its vessels.

The use of various hemostatic agents is a popular method in the control of nasal hemorrhage. Adrenalin solution has long been a favorite. However, its use, as well as that of similar vasoconstrictors, tends to cause recurrence of bleeding after its temporary vasoconstricting effects wear off and secondary vasodilatation appears. This early temporary control of bleeding does, however, allow further inspection of the bleeding area for additional measures. Senturia[12] reviews the use of thrombin solution, oxidized cellulose, fibrin, Gelfoam, etc. These agents have their greatest value in oozing of capillary or venous origin, but should not be expected to control profuse or expulsive arterial hemorrhage. Gelfoam is an excellent car-

rier of thrombin solution and, in contrast to absorbable cotton or cellulose, does not inactivate penicillin. I have found that brisk bleeding from the vomer ridge after a submucous resection, or along the severed nasal processes after a nasal plastic operation, is usually controlled by a strip of Gelfoam moistened with thrombin solution. Houser[13] believes that Oxycel, as a pack, works better when nasal bleeding is associated with alterations in the blood elements, but Hallberg[14] emphasizes that absorbable gauze may cause necrosis of the mucous membrane if packed tightly.

When a brisk hemorrhage is not controlled by these simple measures, an intranasal tampon should be inserted. This is particularly important in expulsive bleeding. Strips of gauze, cotton tampons, or dental cotton rolls, cut in half longitudinally, may be used. These tampons should be pencil-thick and reach posteriorly to the choana, and should be inserted in layers, beginning on the floor of the nose, to accomplish the necessary pressure occlusion of the bleeding area. Such tampons may be impregnated with vaseline or bismuth paste, or with some hemostatic like thrombin solution, tannic acid, or thromboplastin solution. Whatever added value these local hemostatic agents possess, the virtue of the tampons is principally in the pressure effect on the bleeding vessels until their healing through thrombosis occurs. Stevens[15] has invented an inflatable rubber pack for similar effect. In the presence of a deflected septum it may be difficult or impossible to carry out such tamponage effectively. As an alternate procedure, therefore, a long or continuous ½ to 1 inch wide gauze strip may be packed intranasally against a previously inserted postnasal tampon, large enough to occlude the choana. Postnasal plugs of cotton should never be used, because their subsequent maceration and sogginess make their removal most difficult.

When antibiotics are administered intranasal packing may be left in place as long as 10 days without fear of secondary infection. Usually five days is the longest time necessary to allow sufficient healing of the bleeding vessels in hypertension cases or other cases with severe bleeding. The intranasal packing should be removed slowly, one strip or tampon at a time, to allow a gradual return of the compressed vascular bed and prevent a recurrence of bleeding. If profuse bleeding occurs on the removal of the packing after five or six days, external carotid artery and/or ethmoidal artery ligation is indicated.

Ogura and Senturia[16] review the various substances, for administration by mouth or by injection, which have been advocated as adjuvants in the control of nasal bleeding. Thus coagulin, thromboplastin, Koagamin, calcium, vitamin K, snake venom, etc., have been recommended, but are of doubtful or no value in massive blood loss.[17] Blood calcium deficiency sufficient to cause bleeding is incompatible with life. ACTH in hemolytic anemia and some thrombocytopenic purpuras appears to have given good results as a temporary measure. For the massive blood loss, however, there is no substitute for whole blood transfusion, since replacement with plasma or fluids results in dilution of the depleted red cells, which may result in anoxia.

Reppert[17] discusses the problem of bleeding in prothrombin deficiencies. These are due largely to disturbances of the liver, such as cirrhosis or obstructive jaundice, and to faulty absorption, as in sprue. Here large doses of vitamin K are frequently successful, but vitamin K and/or blood transfusions may be necessary if the bleeding is massive. Massive bleeding from Dicumarol prothrombin deficiency demands whole blood transfusions and large doses of vitamin K or vitamin K oxide, since there is little danger of precipitating excessive clotting with vitamin K in a patient with normal prothrombin time. Bleeding from excessive heparin administration *per se* can be controlled by protamine sulfate. Heparinoid substances resembling heparin, found in leukemia, aplastic anemia, lymphosarcoma, Hodgkin's disease, and other blood dyscrasias, are best controlled by whole blood transfusions.

The local use of radium has been advocated and used in the treatment of recurrent epistaxis in nasal telangiectases.[18, 19] However, Weiss[20] reports a case in which there was a recurrence of nasal hemorrhage, in the same amount as before, six months after the application of radium in the highest dosage thus far used in any case. O'Kane[21] used repeated injections of 5 per cent quinine in urethane solution into the telangiectatic areas as an effective measure. In recurring epistaxis from areas of scabbing and ulcera-

tion in the Kiesselbach–Little area, Rainey[22] performs a submucous resection of this area with good results. As an alternate procedure, submucous lifting of this area has also been recommended.

Blood Supply of the Nose

When considering vessel ligation for the control of nasal hemorrhage, a knowledge of the anatomy of the blood supply of the nasal fossa is essential. Burnham[23] gives an accurate, detailed description of the vascular supply of the nasal fossa.

The sphenopalatine branch of the internal maxillary artery, a direct branch of the external carotid, is the principal supply to the lateral nasal wall. It enters the nose through the sphenopalatine foramen and divides into the inferior turbinate, middle turbinate, and nasopalatine arteries. The inferior turbinate terminal branches supply the inferior turbinate body and part of the common inferior and middle meatus. It gives a branch to the antrum, and not infrequently to the ethmoid cells, and communicates with the descending palatine artery. The middle turbinate branch courses along the outer surface of the middle turbinate and, at its middle fifth, divides into terminal branches which form a plexus of the anterior tip of the middle turbinate where it anastomoses with terminal branches of the anterior ethmoidal artery.

The nasopalatine artery leaves the sphenopalatine foramen, courses along the anterior–inferior border of the sphenoid bone to the septum, and then runs downward and anteriorly along its lower border. Before it leaves the lateral posterior wall, it gives off the superior turbinate artery, which anastomoses with the terminal branches of the posterior and anterior ethmoidal arteries. The main branch continues along the attachment of the superior turbinate body to supply the posterior ethmoidal cells, and its terminal branches anastomose at the anterior tip of the superior turbinate with branches of the anterior ethmoidal artery.

The septum or medial aspect of the nasal fossa is supplied by the nasopalatine and the anterior and posterior ethmoidal arteries. Its terminal branches anastomose with the terminal branches of the anterior and posterior ethmoidal arteries to form the Kiesselbach–Little plexus on the anterior septum. After passing through the anterior ethmoidal foramen on the ventromedial aspect of the orbit the anterior ethmoidal artery enters the nose through a slit-like foramen at the site of the crista galli and divides into a lateral nasal branch to the upper lateral nasal wall and the artery of the septum. The posterior ethmoidal artery, the smaller of the two and less constant than the anterior, passes through the posterior ethmoidal foramen of the orbit to supply the posterior ethmoidal cells and the dorsal and superior portion of the nasal septum. It also gives off a branch to the lateral nasal wall posteriorly.

The floor of the nose is supplied mainly by a network of inter-anastomosing vessels of the sphenopalatine and the inferior turbinate branch of the sphenopalatine artery.

The venous pathways of the lateral nasal walls also have important considerations. The smaller vessels join to form the larger "jacket plexus" of veins which accompany the larger vessels within the bony canals of the turbinates in their posterior half. They then leave the canals, passing into periosteal veins again before reaching the sphenopalatine foramen. There is a substantial venous plexus in the mucoperiosteum of the nasal floor.

Indications for Ligation of the External Carotid and Ethmoidal Vessels

Vessel ligation is indicated whenever severe nasal bleeding persists or recurs in spite of repeated packing and blood transfusions. It is not safe to wait until collapse from shock and blood loss.

As a general rule, bleeding from the lateral nasal wall below the superior turbinate body can be controlled by external carotid artery ligation and the area above the superior turbinate body by ethmoidal ligation. Where the two systems form an anastomotic plexus of arterioles, the external carotid supply is to be considered first. When there is some question as to the source of bleeding, an arrest or marked decrease of bleeding upon digital compression of the common carotid artery in the neck strongly suggests that the hemorrhage is from the external carotid supply. Profuse bleeding following nasal bone fractures as a rule involves the ethmoidal arteries. Ligation of the internal carotid artery should never be resorted to in ethmoidal bleeding because it does not eliminate anastomosis of vessels within the circle of Willis.

There are numerous cases in the literature in which external carotid and/or ethmoidal vessel ligation had to be resorted to for the control of severe nasal bleeding. Since the greater blood supply of the nasal fossa is from the external carotid system, the indications for external carotid ligation occur more frequently. In such cases, the etiology of hypertensive disease and arteriosclerosis is most frequently encountered, especially in patients past 60 years of age. Woodruff[2] found that most cases of bleeding in hypertensive arterial disease arose from the posterior lateral region of the inferior meatus, and he performed external artery ligation when bleeding was uncontrolled by packing. Hirsh[24] also recognized the danger and severity of such posterior nasal bleeding and reports 3 cases which were controlled by ligation of the internal maxillary artery, a branch of the external carotid. Johnson and Foster[25] report a case of posterior nasal bleeding following trauma which recurred on the seventh and ninth days in spite of packing. An external carotid ligation temporarily controlled the bleeding, but the bleeding recurred 5 and 7 days later in spite of the anterior and posterior nasal packs inserted at the time of the ligation. There was no further bleeding on the removal of these packs on the tenth day. Although the bleeding vessel could not be visualized because of a septal deviation, the source of bleeding was presumed to be the external carotid, and the recurrence of bleeding after ligation was considered to be the result of collateral circulation from the opposite external carotid. Ligation of the opposite external carotid was considered if further hemorrhage occurred.

Oppenheim *et al.*[26] believe that ligation of the ethmoidal vessels becomes obligatory when ligation of the external carotid artery fails to control the nasal hemorrhage. They review the subject of ethmoidal bleeding and report 2 cases (in addition to 15 previously reported) in which ethmoidal vessel ligation controlled the hemorrhage after external carotid ligation had failed. They believe that interruption of the anterior ethmoidal artery alone would have been sufficient in these cases if it had been possible to ascertain the origin of the bleeding. It should be noted that the ethmoidal vessels are often torn in severe nasal fractures. Davis[27] reports such a case of fatal hemorrhage in which no ligation was performed.

Technic of Vessel Ligation

Ligation of the external carotid artery can be easily performed under local anesthesia. The common carotid artery[28] courses almost perpendicularly in the cervical neck region and divides into the external and internal carotid branches at the level of the superior margin of the thyroid cartilage. With a small sand bag under the shoulders and one to support the neck, the head is slightly extended and turned to the opposite side. An incision is made along the anterior border of the sternocleidomastoid muscle from just beneath the mastoid tip to the inferior margin of the larynx, dividing the skin, platysma, and superficial fascia. The facial vein which crosses the operative field at the level of the common carotid artery bifurcation is doubly ligated and divided. The pulsation of the common carotid artery under finger palpation identifies the position of the artery. The sternocleidomastoid muscle is then drawn outward and the medial structures are drawn medially with retractors. By careful incision or blunt dissection of the carotid fascial sheath, the descending branch of the hypoglossal nerve is identified and displaced medially. The large blue jugular vein, which is exposed, is retracted laterally. Just after the bifurcation of the common carotid, the external carotid artery lies medially and a little anterior to the internal carotid, and is further identified from the internal carotid by its many branches, running medially and inward. The internal carotid by contrast has no branches in the neck, or rarely only one, the superior thyroid. Ligation of the external carotid should be performed close to the bifurcation of the common carotid, below the branches of the external carotid. The neck wound is closed in layers. No drain is necessary.

Ligation of the ethmoidal arteries is not a difficult procedure and is accomplished under local anesthesia as first described by Sewall[29] in his ethmosphenoid-frontal sinus approach. Smith[30] developed special self-retaining retractors which facilitate the exposure of these vessels. The incision begins just below the eyebrow and curves downward and around the inner canthus of the eye, down through the periosteum. The periorbita is freed laterally along the orbit to

expose the ethmoidal vessels. A Yankauer needle, threaded with a No. 0 catgut suture, is passed under the anterior ethmoidal artery and the suture is pulled up out of the wound by a dural hook. The knot is made outside the wound and then tied by a ligature carrier. The wound is closed by a few interrupted sutures. Instead of a suture, a silver clip may be applied to the anterior artery and then severed by electrocoagulation. Severing the artery should be medial to the interruption of the blood flow. The posterior ethmoidal artery is considered to be of little importance in nasal bleeding, but should be coagulated to interrupt this source of blood supply.

Summary

Epistaxis is a common condition encountered by the physician. Its control depends upon the severity, site, and cause of the hemorrhage. Various local methods are advocated, depending upon the nature of the epistaxis. Hospitalization is often necessary for its diagnosis and control. Severe nasal hemorrhage occurs frequently in arteriosclerosis and hypertensive disease, and extensive nasal fractures. Ligation of the external carotid artery and/or the ethmoidal arteries is often necessary to control severe or recurring nasal hemorrhage.

---

212 West Wisconsin Avenue.

REFERENCES

1. Spar, A. A., and Hallberg, O. E.: Severe epistaxis and its management; report of 11 cases in which the external carotid artery was ligated, Ann. Otol., Rhin. & Laryng. 56:141–151 (March) 1947.
2. Woodruff, G. H.: Cardiovascular epistaxis and the naso-nasopharyngeal plexus, Laryngoscope 59: 1238–1247 (Nov.) 1949.
3. Bean, W. B.: Infarction of heart; morphological and clinical appraisal of 300 cases; predisposing and precipitating conditions, Am. Heart J. 14: 684–702 (Dec.) 1937.
4. Long, A. E.: Amaurosis following nasal hemorrhage; report of case, Am. J. Ophth. 26:1179–1182 (Nov.) 1943.
5. Barker, G. N.: Serious epistaxis, J. Laryng. & Otol. 58:293–295 (July) 1943.
6. Abrahams, B. H.: Ligation of the external carotid artery for persistent nasal hemorrhage, Arch. Otolaryng. 8:29–31 (July) 1928.
7. Strauss, A.: Epistaxis in pregnancy requiring ligation of the external carotid, Ann. Otol., Rhin. & Laryng. 42:230–239 (March) 1933.
8. Cody, C. C.: Epistaxis: etiology, anatomy, and surgical pathology, Texas State J. Med. 48: 256–259 (May) 1952.
9. Dohlman, G.: Die Entstehungsweise des Nasenblutens, Acta oto-laryng. 26:575–591, 1938.
10. Fox, S. L.: Treatment of epistaxis by sclerosing injections, Laryngoscope 54:398–401 (Aug.) 1944.
11. Asherson, N.: Epistaxis: its treatment by submucous injections, J. Laryng. & Otol. 49:180–181 (March) 1934.
12. Senturia, B. H., Ogura, J. H., and Walsh, T. E.: The use of thrombin and absorbable sponge for hemostasis in otolaryngology, Laryngoscope 59: 1068–1083 (Oct.) 1949.
13. Houser, K. M.: Oxidized cellulose gauze packing for nasal bleeding, J. A. M. A. 132:143 (Sept. 21) 1946
14. Hallberg, O. E.: Nosebleed and its management, Mississippi Doctor 28:223–228 (Dec.) 1950.
15. Stevens, R. W.: Improved intranasal packing; rubber pneumatic pack, Arch. Otolaryng. 23: 232–235 (Feb.) 1936.
16. Ogura, J. H., and Senturia, B. H.: Epistaxis, Laryngoscope 59:743–763 (July) 1949.
17. Reppert, L. B.: Epistaxis: treatment of massive blood loss, Texas State J. Med. 48:264–266 (May) 1952.
18. Scal, J. C.: Telangiectasis of the nasal septum treated with radium, Arch. Otolaryng. 8:312–314 (Sept.) 1928.
19. Sterman, M. M., and Scal, J. C.: Familial telangiectasia with recurring epistaxis successfully treated with radium, New York State J. Med. 37:287–292 (Feb. 1) 1937.
20. Weiss, J. A.: Radium therapy for recurrent epistaxis in hereditary hemorrhagic telangiectasia, Laryngoscope 48:865–869 (Dec.) 1938.
21. O'Kane, G. H.: Hereditary multiple telangiectasis with epistaxis; method of treatment, J. A. M. A. 111:242–244 (July 16) 1938.
22. Rainey, J. J.: Nose bleeding, Laryngoscope 41: 173–174 (March) 1931.
23. Burnham, H. H.: An anatomical investigation of blood vessels of the lateral nasal wall and their relationship to turbinates and sinuses, J. Laryng. & Otol. 50:569–593 (Aug.) 1935.
24. Hirsch, C.: Ligation of the internal maxillary artery in patients with nasal hemorrhage, Arch. Otolaryng. 24:589–593 (Nov.) 1936.
25. Johnson, M. C., and Foster, M. E.: Ligation of the external carotid artery for traumatic nasal hemorrhage, Ann. Otol., Rhin. & Laryng. 42: 588–591 (June) 1933.
26. Oppenheim, H., *et al.*: Surgical interruption of the anterior ethmoid artery in severe epistaxis, A. M. A. Arch. Otol. 56:448–451 (Oct.) 1952.
27. Davis, E. D. D.: Severe epistaxis, difficult to control, Brit. M. J. 1:721–723 (April 8) 1939.
28. Kirscher, M., Lautenschläger, A., and Kleinschmidt, O. (translation by Ravdin, I. S., and Coates, G. M.): Operative Surgery: The Ear, Air Passages, and Neck, Philadelphia, J. B. Lippincott Co., 1937.
29. Sewall, E. C.: External operation on the ethmosphenoid frontal group of sinuses under local anesthesia; technic for removal of part of optic foramen wall for relief of pressure on optic nerve, Arch. Otolaryng. 4:377–411 (Nov.) 1926.
30. Smith, F.: Management of chronic sinus disease, Arch. Otolaryng. 19:157–171 (Feb.) 1934.

Hepatorenal Glycogen Disease

By ANTHONY J. RICHTSMEIER, M. D., and JOHN ALLEN, M. D.
Madison

IN 1929, Von Gierke reported a clinical syndrome encompassing an enlarged liver, kidney, and other internal organs, due to excessive deposition of glycogen. To date there is a wide variation in the number of cases reported, ranging from 50 to over 200, depending upon the diagnostic criteria employed.[1] Mason and Anderson[2] list a detailed plan for classification of the glycogen storage diseases. They consider the deposition of glycogen in the liver necessary for the diagnosis of true Von Gierke's disease. At least two distinct types of glycogen storage disease have been reported, the cardiac and the hepatic type. Di Sant' Agnese, Anderson, and Mason[3] believe that these two types never co-exist. The cardiac type has widespread involvement of tissues with glycogen, associated with an enlarged heart, and with death usually occurring in the first year of life. In the hepatic type, excess glycogen deposits are usually limited to the liver and kidneys. The involvement of the kidneys conceivably might be due to an effort by the renal system to excrete the excess of glycogen. Glycogen is deposited in the proximal convoluted tubules, and in the case here reported, probably accounts for the persistent microscopic hematuria.

There has been much investigation as to the nature of the basic disturbance,[4] but as yet the real answer awaits positive evaluation. Bridge and Holt[5] state that to classify the entity of the glycogen storage disturbance into the true Von Gierke's hepatic type, the following criteria should be met: (a) enlarged liver, (b) hypoglycemia and ketosis, (c) diminished glycemic response to epinephrine, and (d) chemical analysis showing 12 to 16 per cent glycogen per weight in liver, and no marked increase in fat, plus abnormal stability of liver glycogen after death or *in vitro*. This stability is believed to be due to the absence of the water soluble glycogenolytic ferment present in normal liver. Most organs which contain excessive amounts of glycogen will be enlarged. The general architecture of the organ is preserved, and each element, such as the lobule of the liver, is thickened or increased in size. The cytoplasm contains countless small vacuoles of glycogen, or it may present a reticulated appearance. The nucleus of the cells containing glycogen will usually be found in the center of the cell. In the so-called cardiac type of glycogen disease, the fibers in the myocardium are found to be widely infiltrated with glycogen. In this type almost every other organ, as well as skeletal and smooth muscle, will show an excess of glycogen deposition. The observation that glycogen stored in the fetal liver is relatively stable suggests a fetal condition being prolonged into childhood.

A brief consideration should be given to the factors controlling normal carbohydrate metabolism. Sugars in the form of disaccharides and polysaccharides are converted into monosaccharides (glucose, levulose, and galactose) by action of the salivary and intestinal enzymes. These monosaccharides are absorbed almost exclusively from the intestine and carried to the liver in the portal circulation. The absorption of glucose from the small bowel is quite constant, regardless of the amount of sugar present or the concentration in which it is introduced. The rate of absorption of the various monosaccharides seems to be related to the rate of phosphorylation in the intestinal mucosa. Upon reaching the liver, glucose can be stored as glycogen, utilized in the liver, or, if present in excess, passed into the systemic circulation. The transformation of glycogen into glucose in the liver is effected by enzyme activity and by one or more of several external factors such as a fall in the blood sugar level or administration of epinephrine. In normal subjects, the oral administration of 50 to 100 Gm. of glucose will cause the blood sugar to rise sharply, reaching a maximum of 40 to 50 mg. per hundred cubic centimeters above the fasting level within the first hour. Following this, there is a return to the normal fasting level at the end of one and one-half hours, a subsequent fall to a slightly sub-fasting concentration at about two hours, and a return to fasting level at three to four hours. After intravenous injection of 0.1 unit of insulin per kilogram of

body weight, the blood sugar falls to about 50 per cent of the fasting level 20 to 30 minutes after the injection. It then rises rapidly, reaching the pre-injection level in 90 to 120 minutes. The duration of the hypoglycemia is of greater significance than its degree. The epinephrine tolerance test is used as an index as to the quantity and availability of the glycogen in the liver. After the intramuscular injection of 1 cc. of a 1:1,000 solution of epinephrine, the blood sugar concentration normally increases 35 to 45 mg. per hundred cubic centimeters in 40 to 60 minutes. returning to the resting level in 1 to 2 hours.

Because intercurrent infections have been the most frequent cause of death in these patients with glycogen storage disease, the need for early and correct diagnosis becomes much more important with the advent of antibiotics, as the majority of these patients usually present themselves at a very young age to the physician. The principal symptoms are usually those related to hypoglycemia or cardiac insufficiency, whereas the predominant physical signs are invariably abdominal distention, an enlarged liver or heart, and retarded physical growth. The case here reported demonstrated most of the symptoms and signs, and is of interest because of the unusual clinical course exhibited.

Report of a Case

History. In April 1952 a 12-year-old white boy was brought to his family physician with the complaint of a persistent cold. He had been continuing his usual activities until about 10 days before, when he had noted nasal discharge, sore throat, and loss of appetite, accompanied by an evening temperature elevation of 1 to 2 F. The patient's parents further stated that the child had always been thin and had had a rather large abdomen since birth. There were two older sisters in the family, neither of whom showed any suggestion of a similar condition. The patient was treated at home with bed rest, salicylates, and forced fluids. After a period of six days, the child began to have periorbital edema in the morning and complained of vague right upper quadrant discomfort.

Physical Examination. The boy was thin and underdeveloped. There were non-tender cervical and submental lymph nodes bilaterally measuring 0.5 to 1.0 cm. in diameter. There was edema of the periorbital soft tissues, and a positive centrifugal pulse was present in the right jugular vein. The heart was not enlarged, and the lungs were clear. The abdomen was protuberant, and the liver was slightly tender, with a smooth edge, and was enlarged to 7 cm. below the right costal margin. The blood pressure was 120/70 mm. of mercury.

Laboratory. Urinalysis: specific gravity, 1.017; acid reaction, trace of albumin; 4 red cells per high power field; 2 to 4 white cells per high power field; rare bacteria and occasional epithelial cells. Five additional urinalyses during the period of hospitalization revealed the same findings, with albumin ranging from a trace to a strong 1 plus, and persistence of red and white blood cells averaging 5 to 10 per high power field. Hemoglobin, 78 per cent; red blood cell count, 3,730,000; white blood cell count, 5,650; neutrophils, 46 per cent; eosinophils, 1 per cent; lymphocytes, 53 per cent. Fasting blood sugar, 56 mg. per hundred cubic centimeters; nonprotein nitrogen, 33 mg. per hundred cubic centimeters; prothrombin time, 14.2 seconds, control, 12.7 seconds; icterus index, 5 units; total protein, 7.2 Gm. per hundred cubic centimeters; albumin, 3.7 Gm.; globulin, 3.5 Gm.; serum cholesterol, 140 mg. per hundred cubic centimeters; platelet count, 352,000. Hanger's test was negative in 24 and 48 hours; the sedimentation rate was 46 mm. in 1 hour, Westergren method. Three blood cultures taken over a 10-day period were all negative. The results of the glucose tolerance, epinephrine sensitivity, and insulin sensitivity tests are recorded in the table. Scout films of the abdomen demonstrated increased density in the right upper quadrant consistent with hepatomegaly. The spleen shadow was likewise visualized and appeared to be slightly enlarged.

	Glucose Tolerance	Epinephrine Sensitivity	Insulin Sensitivity
Fasting	76 mg. (50 Gm. glucose given orally)	72 mg. (7 minims of 1:1,000 epinephrine given subcutaneously)	88 mg. (3 units reg. insulin given I.V.)
30 min.	108 mg.	106 mg.	44 mg.
60 min.	68 mg.	106 mg.	64 mg.
120 min.	84 mg.	76 mg.	72 mg.
180 min.			80 mg.

Kidney studies, including cystoscopy, and retrograde and intravenous pyelograms, revealed a normal genitourinary tract. Urine

cultures were positive for Streptococcus faecalis. Sternal marrow aspiration was normal except for an increase in eosinophilic myelocytes. Gastrointestinal series, barium enema, and electrocardiogram failed to reveal any abnormality.

A liver biopsy was advised, but refused until two months later, when it was performed by laparotomy. Grossly, the liver was found to be enlarged and discolored and had the fatty infiltration suggestive of an early cirrhosis. The stomach, small bowel, and spleen appeared normal on both inspection and palpation. A biopsy of the liver was taken and immediately fixed in absolute alcohol. (Absolute alcohol must be employed to demonstrate glycogen in tissue, as the glycogen is soluble in water and is readily dissolved by a watery fixative such as formalin.) See Figs. 1 and 2.

Comment. The prime disturbance in Von Gierke's disease appears to be impaired liver glycogenolysis, and there is recent evidence to show that conversion of carbohydrate to glycogen is also impaired. Analysis of glycogen from liver and muscle[6] has demonstrated a deficiency in either glucose-6-phosphatase or amylo-1, 6-glucosidase. The decrease in the former enzyme system was marked in the liver homogenates taken from mild cases of Von Gierke's disease, while in the severest cases practically no glucose-6-phosphatase activity could be demonstrated. This deficiency accounts for the accumulation of glycogen in the liver but not in muscle or heart tissue, as this enzyme is normally absent from these tissues. A deficiency of some other enzyme could account for this phenomenon. Growth hormone[7] has recently been shown to affect carbohydrate metabolism. Because of the retarded growth displayed by the patients with hepatorenal glycogen disease, the administration of this hormone would seem worthy of trial. It has been demonstrated, however, that growth hormone has a nitrogen-retaining action, thus decreasing gluconeogenesis. It has likewise failed to facilitate glycogenolysis and tends to inhibit the peripheral utilization of carbohydrates.

The case here reported is interesting in several aspects. The patient's course had been relatively uneventful until the age of 12, except for abnormalities in liver size and sugar metabolism. The primary disorder was best exemplified by a consistency of renal findings. A thorough search of current literature and textbooks relative to kidney disease fails to find Von Gierke's disease among the causes of persistent albuminuria and microscopic hematuria. In contrast, acetonuria and ketosis are usually listed as diagnostic criteria, but were never demonstrable in our repeated examinations of this patient. Follow-up urinalyses have shown a persistence of findings and there is no evidence to attribute the above to a transient nephritic process or urinary tract infection. It should be noted also that a normal or near-normal fasting blood sugar does not exclude the possibility of Von Gierke's disease, as demonstrated in the table. In spite of the familial tendency, neither of the sisters presents a similar picture, and it is noteworthy that there has been no instance in the literature of concurrent hepatic and cardiac type ex-

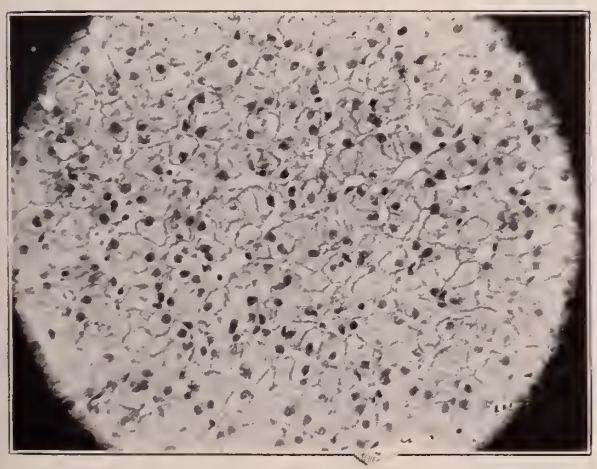


Fig. 1—High power view of liver cells specially stained, showing accumulation of glycogen granules.

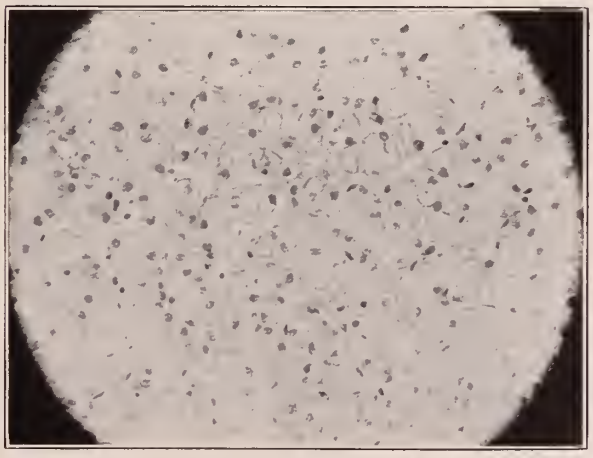


Fig. 2—View of liver cells, demonstrating reticulated and vacuolated appearance because of excess accumulation of glycogen.

isting in the same family. When last examined (on May 23, 1953), this patient showed a weight gain of 7 lb. in the last year. The spleen was no longer palpable, and the liver size had decreased to 3 cm. below the right costal margin. The hemogloblin was 13.3 Gm; no albuminuria was demonstrated, but occasional red blood cells were present in the centrifuged specimen. This clearly demonstrates the tendency reported by some authors[8] for spontaneous improvement about the time of puberty.

To date, no known specific treatment exists. Lowrey and Wilson[9] utilized frequent feedings at 5 to 6 hours of a diet low in carbohydrates and high in protein, the rationale of this routine being that the slow gluconeogenesis supplied by a high protein diet will supply the body with a more constant source of glucose and the low carbohydrate intake may reduce the amount of glucose converted into glycogen and stored as such. Hepatomegaly, hypoglycemia, and acetonuria still remain, but the hypoglycemia is less marked. McQuarrie[10] found that ACTH administration resulted in temporary correction of acetonuria and hypoglycemia. In those patients who have survived to adolescence before their condition was discovered, the outlook is usually quite good, possibly because of control of intercurrent infection, which heretofore has been the most common cause of death.

Conclusion

A case of Von Gierke's disease discovered in a 12-year-old boy is presented. Except for hepatomegaly, the presenting findings were renal in nature and were unusual in that albuminuria and microscopic hematuria persisted. The abnormalities in carbohydrate metabolism were typical of those previously described. A review of the basic nature of the disorder is given.

(J. A.) Oscar Mayer and Company.

REFERENCES

1. Crawford, T.: Glycogen disease, Quart. J. Med. 15: 285–298 (Oct.) 1946.
2. Mason, H. H., and Andersen, D. H.: Glycogen disease, Am. J. Dis. Child. 61:795–825 (April) 1941.
3. di Sant' Agnese, P. A., Andersen, D. H., and Mason, H. H: Glycogen storage disease of the heart, Pediatrics 6:607–623 (Oct.) 1950.
4. van Creveld, S.: Glycogen disease, Medicine 18: 1–128 (Feb.) 1939.
5. Bridge, E. M., and Holt, L. E., Jr.: Glycogen storage disease; observations on pathologic physiology of 2 cases of hepatic form of the disease, J. Pediat. 27:299–315 (Oct.) 1945.
6. Glycogen Storage Disease, editorial, J. A. M. A. 151:560 (Feb. 14) 1953.
7. Growth Hormone and Carbohydrate Metabolism, editorial, J. A. M. A. 150:1602–1603 (Dec. 20) 1952.
8. Langewisch, W. H., and Bigler, J. A.: Disorders of glycogen metabolism, with special reference to glycogen storage disease and galactosemia, Pediatrics 9:263–279 (March) 1952.
9. Lowrey, G. H., and Wilson, J. L.: Observations on the treatment of a case of glycogen storage disease, J. Pediat. 35:702–709 (Dec.) 1949.
10. Mote, J. R., editor: Proceedings of the First Clinical ACTH Conference, Philadelphia, The Blakiston Company, 1950.

IMPORTANT NOTE TO READERS OF "AEROSOL THERAPY IN CHILDREN"

Use Alevaire with extreme caution in the "Isolette" incubator

(The following letter was written by Frank C. Stiles, M. D., whose "Aerosol Therapy in Children" appeared in the October 1953 *Journal.*)

To the Editor of *The Wisconsin Medical Journal:*

Since the publication of the article "Aerosol Therapy in Children," the manufacturers of the "Isolette" have sent out a letter to all users of the incubator stating that extreme caution should be used in the administration of Alevaire in the "Isolette." They emphasize the fact that such wetting agents as Alevaire may damage the rubber parts of the incubator and interfere with humidity and temperature control. It has come to my attention that several hospitals have had to discontinue the use of Alevaire in the "Isolette" for such reasons.

The manufacturers of the "Croupette" state that there are no harmful effects from using the wetting agents in this type of tent.

It is therefore recommended that Alevaire administration in the "Isolette" be limited to a short period and that the "Isolette" be thoroughly cleaned after use.

FRANK C. STILES, M. D.
Department of Pediatrics
The Monroe Clinic

Temporal Arteritis

A Review of Two Cases

By JAMES C. CURRY, M. D.
Milwaukee

TEMPORAL arteritis was first described as a clinical entity by Horton, Magarth, and Brown in 1932. Since this time over 100 cases have been reported in the literature. From these cases a general picture of the disease and the extent of its effect on the general condition of the patient can be obtained.

The patient complains of weakness, early fatigability, loss of weight, and severe headache, often becoming worse at night. Visual disturbances may be described. Some patients may have muscle and joint pain or joint swelling and stiffness. Cerebral symptoms have been noted. Patients may enter with the principal complaint of anginal attacks. These patients are generally over 60 years of age. Approximately twice as many women as men have the disease. The patient appears to be in pain. Fever is variable, ranging from normal to 103 F., with an average of 100 F. to 101 F. orally. There is bilateral prominence and inflammation of the temporal arteries with tenderness over this area. In a review of the literature, Bruce[1] stated that in 40 per cent of the cases of temporal arteritis the eyes may be involved. He further noted that this involvement is produced principally by occlusion of the retinal arteries or their branches or by production of ischemia of the optic nerve behind the point of entry of the retinal vessels into that nerve. The eyes may become involved within days or as late as seven months after the onset of the disease. More than one half of those with eye involvement may expect to lose permanently the sight of one or both eyes, and few can expect the return of normal function. Kaye[2] has reported a case of temporal arteritis accompanied by pericarditis, but no further examples of this condition have been observed.

Laboratory examination usually shows an elevated sedimentation rate and moderate elevation of the white blood cell count. A toxic anemia is frequently present. Most blood cultures obtained on these patients are sterile.

The pathologic picture has been well summarized by Jennings.[3] There is a patchy arteritis principally in the aorta and in the arteries to the head and limbs. Microscopic section of an involved artery reveals inflammation at the adventitial medial junction; cellular infiltration of both coats, principally by lymphocytes and histiocytes with medial necrosis; and giant cell formation. There is granulation tissue in both outer coats with secondary collagenous hypertrophy of the intima and increased collagen deposition in the periarterial connective tissue. Thromboses are noted in the smaller arteries.

Patients with temporal arteritis usually show a slow recovery with a tendency to relapse. Crosby and Wadsworth[4] describe a mortality rate of 12.5 per cent with death due to active arteritis and multiple cerebral thromboses.

Therapy in temporal arteritis has run a wide gamut. The various methods employed have ranged from potassium iodide, dicalcium phosphate, liver, thiamin, sodium iodide, sodium salicylate, codeine and morphine sulfate, phenobarbital, cobra venom, Phenacetin, x-ray, various sulfa preparations, antibiotics, and niacin and other vasodilators. In 1948 Roberts and Askey[5] reported 4 cases in which repeated periarterial infusion of 1 per cent procaine relieved pain and in 3 of the cases removed all evidence of inflammation. In one patient a stellate ganglion block was successfully used after several periarterial injections which had failed to relieve the condition. Cohen and Moses[6] in 1951 found that when cortisone was administered before and after passive sensitization to horse serum, the lesions of experimentally produced arteritis in rabbits appeared to be modified but not suppressed. The reason was not understood, but it was hypothesized that perhaps cortisone exerts an effect upon the *in vivo* union of antigen-antibody or may influence the tissue response evoked by an antigen-antibody reaction. Since this work, Aveling and Stevenson,[7] Kristensen,[8] and others have reported

cases of the complete disappearance of symptoms on ACTH therapy. As yet there has been no report of any recurrence. Kristensen has postulated that ACTH combined with Dicumarol may prevent advancement of the condition to the point of involving some vital artery or arteries.

CASE 1—The patient, C. T., was a 58-year-old colored male who entered Milwaukee County General Hospital for the first time on July 31, 1949, with complaints of pain in the neck bilaterally of seven months' duration, with radiation down both arms. The pain had become more severe in the past three months. For one week before entry the patient had noticed weakness, anorexia, and weight loss of undetermined amount. He described the pain at this time as "a rope around the head and neck." He further volunteered that the pain appeared to follow the arteries. His past history included a stroke in 1940 with residual right-sided weakness, blindness of unknown cause since 1930, and treatment for lues in 1929. The patient's oral temperature was 99.4 F., and his blood pressure 160/100. He had bilateral corneal opacities and tender thrombosed vessels of the right arm, cervical, and bilateral temporal areas. Despite the history of a stroke, no abnormal neurologic findings were elicited. His hemoglobin was 91 per cent, white blood cell count 6,900 per cubic millimeter, and sedimentation rate 87 mm. in one hour (Westergren). The differential cell count showed 6 stab forms, 55 segmented cells, 30 lymphocytes, 8 monocytes, and 1 basophil. Both blood and spinal-fluid Wassermann tests were negative.

On Aug. 20, 1949, the patient complained of headache bilaterally and restated that the pain followed the blood vessels. Heat therapy was unsuccessful. On September 1, the white blood cell count was 13,650 per cubic millimeter, with a differential of 3 stab forms, 67 segmented cells, 20 lymphocytes, 9 monocytes, and 1 eosinophil. The sedimentation rate was 121 mm. per hour (Westergren). On September 8, 1 per cent procaine infiltration over the left temporal artery gave marked relief of pain within one-half hour. On September 10, headache was again noted, particularly on the right. After a biopsy of the right temporal artery was performed, there was a marked subsidence of all symptoms. Temperature until this time had ranged from normal to 101.6 F. orally.

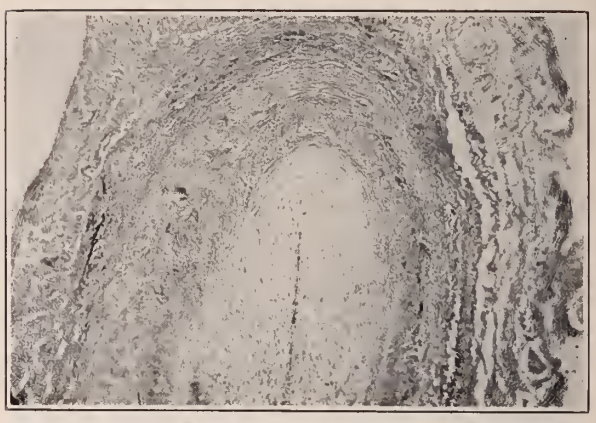


Fig. 1—Cross section of temporal artery of patient C. T. obtained on Sept. 10, 1949, illustrating the obliterative arteritis described in the text.

On discharge September 20, sedimentation rate, white blood cell count, and temperature were all normal and the patient was free of symptoms.

On microscopic examination of the biopsied specimen (Fig. 1), the vessel wall showed a prominent inflammatory reaction consisting of many lymphocytes, some plasma cells, and occasional polymorphonuclear cells. An occasional eosinophil was also noted. Multinucleated giant cells associated with large monocytes were found and small collections of these cells appearing as tubercles were present. Some fibrosis of the intimal surface was observed.

The patient entered the hospital again on Dec. 27, 1949, with the diagnosis of cerebral vascular accident with resultant aphasia and left-sided weakness. Laboratory reports were normal at this time, including negative blood and spinal-fluid Wassermanns. Temporal arteries were prominent but showed no evidence of tenderness or inflammation.

On Nov. 17, 1952, the patient re-entered the hospital with the complaint of left-sided sensory loss. It was noted at this time that the patient appeared euphoric, but no motor disturbance or other neurologic manifestations were elicited. He had no fever, and the temporal arteries were again noted to be tortuous, firm, and non-tender. For the first time a prominent diastolic murmur was noted at the apex with transmission to the aortic area, where it was observed to be of a loud, blowing quality. X-ray of the chest revealed a dilated aortic arch which had not been observed on previous films. Fluoroscopic examination confirmed the aneurysmal dilatation of the arch of the aorta. Laboratory

findings repeated the previously reported negative blood and spinal-fluid Wassermanns. One million units of penicillin aqueous was administered and a blood Wassermann was repeated the following day in an attempt to obtain a therapeutic reversal, since it was felt that the aortic changes were on a luetic basis. The Wassermann was again negative. A biopsy performed at this time on the left temporal artery revealed less evidence of inflammation, but the changes were essentially the same as those found in the right artery three years earlier. The patient was subsequently discharged. Since the original biopsy there has been no recurrence of headaches or inflammation of the temporal arteries.

Comment

This is the second case report of a Negro with temporal arteritis, Bennett[9] having reported the first case in 1951. The nature of the aortic aneurysm is questioned because of the past history of lues; however, it is to be noted that this condition apparently developed after January 1950 and all blood Wassermanns were negative. This is not the usual picture in cardiovascular syphilis. It is felt that the process extended to the cerebral vessels and with the present hypertension was instrumental in producing the cerebral vascular accident and the euphoria and loss of sensation of the left side noted in the last admission.

Case 2—On Nov. 18, 1952, E. D., a 68-year-old white male, entered Milwaukee County General Hospital primarily for evaluation of his anemia, lassitude, and generalized aches and pains. History revealed anginal attacks for four years and a 15-pound weight loss noted in the past month, accompanied by early fatigability and generalized weakness. Examination revealed an afebrile white male appearing pallorous and mildly cachectic. The only significant physical findings were a liver 3 cc. below the right costal margin and an enlarged firm prostate. No abnormalities of the face, scalp, or heart were noted. Laboratory findings revealed a red blood cell count of 4,970,000 and a hemoglobin of 75 per cent with a color index of .79. The white blood cell count was 13,100 cells per cubic millimeter with a differential of 10 stab forms, 63 segmented cells, 13 lymphocytes, 11 monocytes, 3 eosinophils, and a sedimentation rate of 53 mm. per hour (Westergren). The impression on admission was arteriosclerotic heart disease, benign prostatic hypertrophy, and possible generalized carcinomatosis.

Fig. 2—Inflammation of the right temporal artery in patient E. D.

Three days later, on November 21, the patient began to complain for the first time of right-sided headaches. On the following day the first temperature elevation was noted, 99.4 F. Neurologic and funduscopic examinations at this time were normal. On November 25 it became apparent from the patient's description that the pain followed the temporal artery. Pressure on the artery was noted to alleviate the pain. The headaches were continuous, and by December 8 had become severe. At this time it was noted that both temporal arteries had become prominent, tender, and tortuous and that the skin around them was congested. (Fig. 2) Since hospital admission the oral temperature varied from normal to 100.6 F. The white blood cell count ranged from 13,000 to 14,000 and a moderate hypochromic anemia was present.

On December 11, ACTH therapy was instituted in dosages of 20 mg. every six hours; this was changed the following day, however, to 50 mg. of cortisone four times daily. The severity of the headaches immediately diminished, and the patient's temperature returned to normal and stayed there. On December 19, the cortisone dosage was low-

ered to 25 mg. four times daily. At this time headaches were present, but they were of mild, intermittent character. Only moderate evidence of inflammation of the temporal arteries persisted. On December 24, the cortisone dosage was lowered to 25 mg. three times a day, and a biopsy of both temporal arteries was obtained for microscopic confirmation of the diagnosis of temporal arteritis. Both sections microscopically revealed the inflammatory changes characteristic of temporal arteritis as previously described. After biopsy, all remaining evidence of inflammation disappeared. A "step-down" process in the cortisone dosage was employed and on January 12, 1953, dosage was reduced to 25 mg. daily for two days and was discontinued after 12.5 mg. had been given daily for two days. For the past four months this patient has been followed in the outpatient department and no recurrence of symptoms has been noted.

Comment

In this patient the presenting complaint was what may be considered the prodromal phase, and the typical picture of temporal arteritis developed during his hospitalization. The patient had had anginal attacks for four years before the onset of symptoms of temporal arteritis. No increase of symptoms referable to the coronaries was noted after the development of temporal arteritis. This case was, we feel, a significant example of the response of temporal arteritis to cortisone therapy, since biopsy was not attempted until marked clinical improvement was noted. As in Case 1, diagnosis was confirmed by biopsied sections.

Summary

1. The current clinical picture of temporal arteritis is discussed.

2. Two cases of temporal arteritis, proved by biopsy, are reviewed.

3. The second case report of temporal arteritis in a Negro is presented. In this patient, advancement of the condition over a three-and-a-half-year period is noted and an aortic aneurysm of questionable etiology is discussed.

4. A case of temporal arteritis with therapeutic response to cortisone is reviewed.

5. It is of interest to note that both patients volunteered the information that "the pain followed the blood vessels."

9322 West Mount Vernon Avenue.

REFERENCES

1. Bruce, G. M.: Temporal arteritis as a cause of blindness; review of literature and report of case, Am. J. Ophth. 33:1568–1573 (Oct.) 1950.
2. Kaye, S. L.: Temporal arteritis; report of 7 cases, Lancet 1:1039–1042 (June 18) 1949.
3. Jennings, G. H.: "Temporal arteritis"; some aspects of subacute arteritis in later life, Brit. M. J. 1:443–447 (March 6) 1948.
4. Crosby, R. C., and Wadsworth, R. C.: Temporal arteritis; review of literature and report of 5 additional cases, Arch. Int. Med. 81:431–464 (April) 1948.
5. Roberts, A. M., and Askey, J. M.: Temporal arteritis; relief of headache by injection of procaine hydrochloride, J. A. M. A. 137:697–699 (June 19) 1948.
6. Cohen, S. G., and Moses, C.: Effect of cortisone on experimental production of arteritis by passive sensitization, J. Lab. & Clin. Med. 37:764–770 (May) 1951.
7. Aveling, J. V., and Stevenson, F. H.: Temporal arteritis treated with ACTH, Lancet 2:610 (Sept. 27) 1952.
8. Kristensen, H. P. O.: A case of arteritis temporalis treated with ACTH, Acta med. Scandinav. 142: 391–397 (May) 1952.
9. Bennett, H. D., and Baker, L. A.: Temporal arteritis occurring in Negro, Am. Heart J. 42:447–452 (Sept.) 1951.

MARQUETTE POSTGRADUATE COURSE IN PROCTOLOGY

Four lecture sessions at Marquette University School of Medicine and two clinical sessions at the Milwaukee County Dispensary will constitute Marquette's postgraduate course in proctology to be offered during November and December. Lecture sessions will be held on the afternoons of November 18 and December 2, 9, and 16 from 4:00 to 5:30. Clinical sessions are scheduled for the mornings of December 10 and 14 from 10:30 to 12:00.

Albert G. Schutte, M. D., assistant clinical professor of surgery at Marquette, is director of the sessions. The tuition fee for the course is $25.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Some Remarks Regarding Anticoagulant Therapy

The utility of the anticoagulant drugs in the prevention and treatment of thrombotic disease is now quite satisfactorily established. There are several substances now available for clinical use, and others are undergoing experimental study.

Two principal types of drugs are widely used. The first of these, heparin, lowers the coagulability of the blood *in vivo* and *in vitro*. It produces its effect promptly, in minutes or a very few hours, and the effect subsides quickly when the drug is withheld. Heparin is virtually non-toxic in other respects, and since its use is well established and well understood it will not be further discussed here. Its chief disadvantages are its costliness and the necessity for parenteral administration.

The second type of anticoagulant drugs includes the coumarin compounds. Three of them, bishydroxy-coumarin-U.S.P. (Dicumarol), cyclocumarol-N.N.R. (Cumopyran), and ethyl biscoumacetate-N.N.R. (Tromexan Ethyl Acetate), are approved by the U. S. Food and Drug Administration. All three presumably modify the coagulability of the blood *in vivo* by lessening the prothrombin activity of the blood. There is no effect *in vitro*. All three are administered orally and this is of considerable advantage. Of the three drugs, Dicumarol has been used longest and is best known. Its effectiveness is well recognized. There is a latent period of about 24 hours from the time of administration until effect is noted in the blood prothrombin level and 48 to 72 hours until the desired hypoprothrombinemia of 20 to 40 per cent of normal is produced. The latent period for Cumopyran is 18 to 24 hours; optimal effect is achieved in about 24 to 48 hours. Tromexan acts the most quickly, with a latent period of 8 to 12 hours and desirable hypothrombinemia demonstrable in 18 to 36 hours. After cessation of therapy the prothrombin level returns to normal in 4, 8, and 1 to 2 days, respectively, for the three drugs.

Tromexan has the advantage of early action and quick subsidence of effect if excessive hypoprothrombinemia or hemorrhage develops. It has a decided disadvantage in that (for the same reason that the advantages exist) there is difficulty in maintaining the satisfactory 20 to 40 per cent level because of quick and sharp fluctuations of the prothrombin level unless two or three doses a day are administred. Dicumarol administration allows for greater stability of effect, but in our use of Cumopyran during the past three years it has been repeatedly observed that it is easier to maintain the prothrombin level at 20 to 40 per cent of normal by judicious administration of this drug than it is with Dicumarol. For this reason Cumopyran has become our drug of choice.

For all three drugs the dosage must be controlled by accurate daily prothrombin time determinations the first week or two and at frequent intervals thereafter. It is our custom to have the report of the day's prothrombin time available before each dose is given in order to judge its proper size. Since determination of the prothrombin time before the first dose will usually eliminate the hazard of overlooking existing serious liver disease, this determination should always be made.

Excessive dosage of all three drugs may produce hemorrhage, which can usually be controlled with vitamin K_1 or vitamin K_1 oxide but not with vitamin K, but there are practically no other undesirable effects from any of the three drugs. Furthermore, the range between the effective therapeutic dose and the toxic (hemorrhage-producing) dose is wide.

The indications for anticoagulant therapy are now quite well known. However, I wish to emphasize the great need for anticoagulant therapy postoperatively and postpartum in patients who have a history of thrombotic or embolic episodes subsequent to previous operative procedures or delivery. The likelihood that such episodes will recur is high; according to Nelson Barker *et al.*[1] at

the Mayo Clinic, they recurred in over 40 per cent of such patients. Hence the prophylactic administration of anticoagulants in these cases is clearly indicated, and Barker found it to be effective.

Much interest and considerable controversy have arisen regarding the use of anticoagulant therapy in cases of coronary occlusion. It is generally agreed that anticoagulant therapy does not greatly decrease the incidence of subsequent coronary thrombosis. If one grants that coronary thrombosis is chiefly dependent upon arteriosclerosis with narrowing of the lumen rather than upon the status of the blood, it would not be expected that anticoagulants could be very helpful. It appears to be quite evident, however, that by lessening the incidence of mural and intra-auricular thrombosis, and of peripheral venous thrombosis caused by a diminished blood flow and a venous stasis resulting from a weakened myocardium and enforced inactivity, the use of anticoagulants helps to diminish the serious and often fatal complications of cerebral and pulmonary embolism. This effects a reduction of mortality of at least 30 per cent. Thus, in my judgment, anticoagulant therapy is usually indicated in patients with coronary artery occlusion. It should be withheld under the circumstances of gross liver disease, hemorrhagic disease, or potential hemorrhagic states such as peptic ulcer or ulcerative colitis, or when *accurate prothrombin time determinations are not available.* If these contraindications are taken into account and if the physician is careful and gives close daily attention to the general status of the patient, the prothrombin level, and the proper dosage of the drug (omitting administration of the drug when the prothrombin is 20 per cent of normal or less), anticoagulant therapy has little risk and should be given. At this time Cumopyran is the anticoagulant of choice for sustained therapy. Therapy should be started with the coumarin compound as soon as the diagnosis is made. It is our custom to administer the anticoagulant until the patient is freely ambulant. Only occasionally is more prolonged therapy indicated as, for example, when there is continued auricular fibrillation along with repeated embolic episodes.

Emphasis in the literature upon the hazards of anticoagulant therapy is proper, but it is the writer's opinion that the reported fatalities caused by hemorrhage[2] are, in most instances, due to inaccuracies in determination of the prothrombin time or to lack of attention to dosage or proper administration of the drug. Hence the anticoagulants themselves should not be held solely responsible. Any other drug which is misused or given without proper supervision is also likely to produce undesirable effects.—OVID O. MEYER, M. D.

REFERENCES

1. Barker, N. W., Cromer, H. E., Hurn, M., and Waugh, J. M.: Use of Dicumarol in prevention of postoperative thrombosis and embolism with special reference to dosage and safe administration, Surgery 17:207–217 (Feb.) 1945.
2. Russek, H. I., and Zohman, B. L.: Anticoagulant therapy in acute myocardial infarction. A survey of specialists' opinions concerning indications, results and dangers. Am. J. M. Sc. 225: 8–13 (Jan.) 1953.

THE WISCONSIN DIABETES ASSOCIATION

Physicians interested in diabetes, as well as laymen who have diabetes or are interested in the problem, are encouraged to join the Wisconsin Diabetes Association. An affiliate of the American Diabetes Association, it has a clinical and a lay organization which work together closely. To date, the Association has sponsored camps for diabetic children, scientific meetings for physicians, educational talks for diabetics, and diabetic detection drives. The lay group of the Milwaukee chapter meets frequently under the guidance of physicians and dietitians.

Annual dues for the Wisconsin Diabetes Association are $5.00 for physicians and laymen alike. Included in the dues is a one-year subscription to *Forecast,* a national publication on diabetes. Membership in the American Diabetes Association, including a year's subscription to the journal *Diabetes,* costs $15.00.

Communities in the state are encouraged to form local chapters within the framework of the Wisconsin Diabetes Association. For further information, write the Wisconsin Diabetes Association, % Wisconsin Heart Association, 642 North Fifth Street, Milwaukee, Wisconsin.

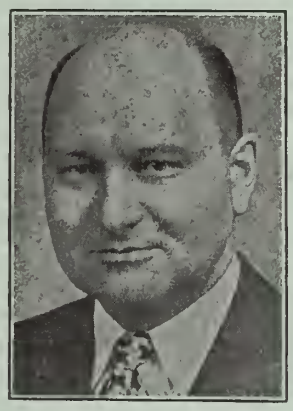
THE MEDICAL FORUM

DESSLOCH TALKS ABOUT FUTURE CATASTROPHIC POLICY

Wisconsin Public Health Council Elects Officers

Madison, Nov. 5.—New officers elected by the Wisconsin Public Health Council at its annual meeting in connection with the Wisconsin Health Conference are Deane Bascom, West Bend, first vice-president, and Dr. Allan Filek, Madison, treasurer. Both succeed themselves in office, for two-year terms.

New directors elected at the meeting were Dr. R. A. Mason, Milwaukee, and Mrs. Caryl Vigdahl, Viroqua. They succeed Dr. W. D. Stovall, Madison, and Miss Susan Normann, Waukesha. Their terms are for three years.



DR. E. M. DESSLOCH

MEDICAL ASPECTS OF CIVIL DEFENSE DISCUSSED AT GOVERNOR'S CONFERENCE

Medical aspects of civil defense were discussed at great length at the Governor's Conference on Civil Defense, which was held in the new University Library on November 2 and 3.

Representatives of a cross-section of Wisconsin leadership were told that first aid training is basic in civil defense preparedness, and that the organization, training and supplying of medical teams to move into action right after enemy attack is vital to both state and local civil defense planning.

Stockpiling of supplies for state mobile medical teams is nearing completion, the conference was told, with blood plasma, litters and litter-cots, and supplies for 102 medical teams being stored at Camp Williams. In addition, Wisconsin will have access to federal medical stockpiles at Bremen, Indiana, in event of enemy attack.

Dr. Arthur L. VanDuser, assistant to Dr. Carl N. Neupert, State Health Officer, who is co-director for health services for the state civil defense organization, participated in a panel discussion which dealt with local and state civil defense problems. He went into considerable detail about what is being done at the state level in providing medical teams and supplies to be made available to a disaster area anywhere in Wisconsin after the Governor declares a state of emergency.

Dr. H. Kent Tenney, president of the Wisconsin State Medical Society, and Dr. Marc J. Musser, chairman of the Society's civil defense committee, attended the Governor's Conference.

A goal of at least one trained first aider in every family has been set by the State civil defense organization. To help make this a reality, school administrators are incorporating first aid training in their school activities.

The matter of emergency feeding, sanitation, housing, and general care of homeless from a disaster area is being developed into a statewide plan to be carried out by public and private welfare agencies.

Designation of civil defense roads to be used as ingress and egress routes for emergency vehicles, including van-ambulances, has been completed and they will be marked shortly, the Conference was told. Organization of transportation pools from which trucks and other emergency vehicles can be obtained is being completed.

Addresses Health Meet on "What We Can Expect from Health Insurance"

Madison, Nov. 4.—The State Medical Society's Blue Shield plan will have a catastrophic medical insurance policy ready for the public early in 1954, according to Dr. E. M. Dessloch, Prairie du Chien, chairman of the society's commission on prepaid plans.

Dr. Dessloch addressed a luncheon meeting of the Wisconsin Health Conference at the Memorial Union in Madison on the subject "What We Can Expect from Health Insurance."

He said that the new policy would have both deductible and co-insurance features. He explained that deductible insurance is of the type that provides all illness expense up to a certain figure, usually 5 to 10 thousand dollars, but starting after payment by the subscriber of the first one or two or five hundred dollars—depending on the subscriber's contract and corresponding insurance rate.

The co-insurance feature means that the subscriber pays a certain percentage, usually 20 per cent, of the costs of a catastrophic illness or injury, while the insurance carrier pays the balance. This feature is designed to discourage malingerers.

Prof. Charles C. Center of the University of Wisconsin's commerce department also talked about health insurance, saying that catastrophic insurance is the great need in the health insurance field today. He agreed with Dr. Dessloch's statement that when you insure against the normal and reasonable medical expenses incurred by nearly everybody, "you just trade dollars with the insurance company."

He warned against commercial sickness insurance policies, many of which, he said, operate on the principle of "the large print giveth and the small print taketh away." He said the mail order health in-

(Continued on page 605)

SOCIETY PROVIDES ALL SORTS OF ADVICE TO MEMBERS

Mrs. Jones is a chronic asthma sufferer. Her physician has used all the means at his command to give her relief, but none of his treatments seems to offer more than temporary relief.

One of her friends has heard of an asthma clinic in Idaho, and she has secured some material about it. She brings it to her doctor and asks him whether he knows anything about this clinic, and whether it is operated by properly qualified doctors on a truly scientific basis.

The doctor has probably never heard of it, unless he has had some dealings with it before. But he can write to the State Medical Society and get all the information about it he needs.

This is just one of hundreds of requests for information and advice which come to the State Medical Society from the physicians who are its members. To answer them, the society has built up a large filing system, and its staff members have at their disposal considerable knowledge of other organizations so that they know where to go for information they themselves do not have available.

Clinic Plans Loaned

If a physician wants to build a new clinic, he can write to the society for the loan of various clinic floor plans which have been designed by prominent architects and used with success by various physicians who have already done their building.

If a physician wants to obtain an assistant, or take another doctor into partnership, the society will try to steer a man to him by means of its placement service. It will also advise him as to legal details and obligations involved in setting up a partnership.

A young doctor just finished with residency training can often find just the location he is looking for with the aid of this service.

When a doctor wants to go away for vacation, but cannot leave his patients unattended, the society can help him locate a locum tenens. Often these substitutes are young physicians not yet located, who are glad to have the experience and make profitable use of the time between the completion of an internship and the start of a residency.

Another important area of advice provided by the society has to do with the relationship of the doctor to the hospital. Most physicians are members of some local hospital staff. Some of them have misunderstandings from time to time with the hospital, regarding the duties, rights, and privileges of staff membership. The society may act as an intermediary in such cases, informing both the physician and the hospital of the usual procedure in similar cases.

> What are the duties the State Medical Society performs for the physicians who are its members? This is the third in a series of articles designed to explain the services of the society.

Legal Advice Offered

Legal advice is available on subjects relating to the fundamentals of medical practice, some of which are very ticklish. It includes advice in regard to possible malpractice suits and interpretation of the laws which concern the dispensing of narcotics and dealing with drug addicts. Legal advice in regard to all sorts of business procedures is also available.

From the society office, the physician can learn the proper procedures to be followed when a couple wishes to adopt a child, when somebody wishes to place a child for adoption, or when a patient must be committed to a mental institution. He can learn what he should do to make donations or bequests for research projects and foundations—and he may be asked about such procedures by patients who have the same thing in mind.

"How shall I go about giving a scientific talk to a lay audience in language it can understand?" This question is answered frequently by the medical society. Staff members help to write speeches and arrange programs for non-scientific consumption. They may also supply pamphlet materials on the cost of medical care, the timing of infant immunization programs, and the like.

Source material for scientific talks and articles is also provided to physicians upon request. The society will often secure a speaker for a local group at the behest of some doctor or his wife. It will also provide advice on films and other visual aids that are available both to audiences of doctors and lay people.

Physicians may also ask and receive advice as to general office policy, various details of business arrangements and efficient billing procedures.

PR Advice Given

Public relations constitute another field in which the society offers help to physicians. This department offers advice regarding contacts with press, radio and television. Doctors may want to know what character of signs are ethical and what sort of advertising they may do under certain conditions.

Three years ago, a special committee was set up by the society to study disability insurance coverage for physicians. This committee selected the program which provided the best benefits at the most reasonable cost, and continues to review the coverage in order to make any changes which are considered necessary in view of present economic trends. This coverage is written for physicians directly with the Provident company, but the society holds the master contract and stands ready to clear up any misunderstandings which may arise between the physician and the insurance company.

Advice is also offered in regard to automobile and liability insurance, and health insurance programs of all kinds.

If You Can't Be at AMA Clinical Session, See Its Highlights on TV

Highlights of the AMA's clinical meeting in St. Louis the first days of December will be telecast at 9 p. m. central standard time over WTMJ–TV.

This will be the third of the fall "March of Medicine" television series sponsored by the American Medical Association and Smith, Kline and French Laboratories of Philadelphia.

Like last year's clinical session television program, this one will cover the major exhibits with explanations to the televiewer.

HEALTH CONFERENCE CITATIONS PRESENTED TO MRS. McCLELLAND, KENOSHA HEALTH COUNCIL

Madison, Nov. 5.—Two awards for outstanding contributions to the cause of community health were presented at the Wisconsin Health Conference in Madison November 4 and 5.

One of these, the Wisconsin Public Health Council Award, was given for improvement in local health conditions accomplished by means of group action, and was awarded to the Kenosha Community Health Council.

This group instituted a health survey with the aid of the State Board of Health. As a result, they have a new, fully qualified public health physician to head their health department, and a qualified supervising nurse.

Dr. W. C. Stewart was chairman of the executive committee appointed by the council to oversee the survey.

The other award, known as the Health Achievement Award, is presented to the individual who has done the most for her community by her own efforts.

Winner of this award was Mrs. Clarence McClelland, Berlin, who has spent most of her spare time during her 35 years of married life assisting voluntary health agencies, 4-H clubs and farm groups to work for better health conditions in Green Lake County.

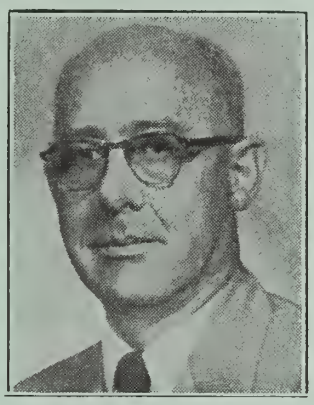
CATASTROPHIC POLICY . . .

(Continued from page 603)

surance companies are the worst offenders.

Prof. Center gave eight points to look for in buying a health insurance policy:

1. Is the policy understandable?
2. Beware of the term "accidental means" in policies which provide benefits for injuries suffered accidentally.
3. Beware of policies that exclude common ailments from benefits.
4. Don't buy limited policies like those offered by newspapers for promotion purposes.
5. Be careful of "dread disease" policies which pay for leprosy but not pneumonia.
6. Check monthly indemnity benefits to be sure the plan will pay each month rather than a small set amount which is explained in fine print.
7. Be extra careful of buying by mail order from companies outside Wisconsin.
8. Buy from well-known, reputable companies licensed in Wisconsin.



DR. RAYMOND HIRSCH

Dr. Hirsch Reappointed to Nursing Homes Group

Madison, Nov. 1.—Dr. Raymond Hirsch, Viroqua, has been reappointed to serve a three-year term on the State Board of Health's advisory committee on nursing homes. Dr. Hirsch represents the field of medicine on this committee.

Meeting at least once a year, this committee advises in regard to the establishment and review of minimum standards for the care of patients in nursing homes and homes for the aged.

Sister M. Clarine, administrator of St. Nicholas hospital, Sheboygan, has been appointed to represent the field of hospital administration on this committee.

Other members include Miss Margaret Healy, Milwaukee, (nursing); Robert B. L. Murphy, Madison, (broad civic interests); Mrs. Mollie Rahr, Manitowoc, (social services); Albert G. Incani, Eau Claire, (nursing home operation); Miss Theda L. Waterman, Milwaukee, (broad civic interests); George M. Keith, Madison, (State Department of Public Welfare); and **Dr. E. H. Jorris**, Madison, (State Board of Health).

According to Bert Bell, Socialized Medicine Is Real Political Football

New York, Oct. 19.—Bert Bell, commissioner of the National Football League, rang socialized medicine in on his annual report to New York football writers.

Said Bell, "The National League will win the television suit brought against them by the government because we are not going to stand for socialized medicine and we are not going to stand for socialized TV."

The government fight contests the right of a football team to black out television showings in the area where the game is being played. The league says such a black-out is a necessity "to protect our home gates."

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

A Forum Feature

Demands Increase

"LET'S NOT HAVE GOVERNMENT TINKER WITH MEDICINE"

By Esther Hammill Draheim

Mrs. William A. Draheim, Neenah, wife of a state senator, made a fact-finding tour of the British Isles and Europe last summer for the Appleton Travel Bureau, for which she does promotional work. This is the second of two articles about socailized medicine as she observed it which she wrote after her return.

The Labor government took over in 1945. A cradle-to-the-grave social security system, which included national health insurance, became law in 1948. In 1951, this government was defeated by the Conservative (Churchill) government by a slight majority.

In May, while I was there, the borough elections took place and the voting was heavily Labor again. My friends discussed it from one point of view, but, as the old saying goes, there are two sides to everything. I was curious enough to want to get the other side.

"I Ask Cabbies"

I always have had a great respect for city taxi cab drivers' opinions at home. They always have an answer to any question put to them, and they comment with the assurance of one having just come fresh from a cabinet or executive meeting. And well they might have, for the front seat of a cab is a strategic spot from which to hear and learn many things. I have yet to see a cabbie with cotton in his ears or, for that matter, one with buttons on his lips.

I had occasion to ride a cab the next day after elections, so I asked the cabbie why the voting was going Labor-Socialist again. In true form, he gave me the answer.

"They're tinkering with our medicine, and we don't like it."

"Tinkering," said I. "What do you mean? Don't you still have free medicine?"

"Not like we had it. He (Churchill) makes us pay half for our teeth and our eyes."

I was secretly amused at that when I thought of the conversation I had heard a few evenings before about a man who worked around the apartment building in which my friend lived. He had had his teeth pulled four months previously and was still waiting for his plates. He was being constantly ribbed about his shrinking gums and wizened facial expression, but thought nothing of waiting another four to six months, as he was expecting to have to do. An English woman told me, "Everyone was having his teeth pulled. They had to have new plates because they were free."

I found out more from the cabbie than I had anticipated. The voters were going back to the Labor government, bait, hook, line and sinker, because the Conservatives had tinkered with their "free medicine."

I recalled vaguely all the talk back home in the States about socialized medicine—National Health Insurance. Now that I had seen how it worked first hand, I realized how apathetic most of us are about it.

Can Be Thrust on Us

I am not a propagandist, not a politician, and not a journalist, as you have no doubt concluded by now, but I have written this letter with the hope that others will be aroused to the dangers of having socialized medicine thrust upon us by the planners.

I'm sure we Americans would be very unhappy with it. Another old saying, "Whether it's better to endure the ills we have than fly to others that we know not of," is food for thought. Rather let us leave our medicine in the hands of men who know about it and, by continuing to improve what we have, keep it the best medicine in the world.

In the words of the English cab driver, let's not let the government tinker with our medicine. We won't like it.

I found traveling in Europe quite wonderful and simple. Tourism for Europe is big business, and well it can be because of the marvelous old culture and present-day interest found there.

I found each country different. Each has its own customs and way of life, and I'm certain each prefers its own. The people are fiercely loyal to their own countries too, just as we are to ours.

The one marked similarity everywhere is the babies and small children. They seem exactly alike emotionally, everywhere. They have no fears, no prejudices, no hatreds. Perhaps in them lies the future peace of the world, if we can keep from them the past.

Hearings on Voluntary Health Insurance Are Halted by Committee

Washington, Oct. 16.—The House Interstate and Foreign Commerce Committee health hearings were halted October 14 after two days of testimony on the extent of health insurance coverage in this country.

Three additional days of hearings, at which Blue Shield, Blue Cross, labor groups and others were to testify, were cancelled.

Chairman Charles Wolverton of New Jersey explained that the committee had gathered so much material since it began hearings October 1 that it had become necessary to call a halt so that the committee might analyze the testimony to date. He said hearings would doubtless be resumed at some future date, but set no time for their resumption.

Witnesses from both insurance companies and business firms with health plans stressed the importance of the voluntary approach. The insurance manager of one corporation stated:

"It is fortunate that the voluntary health insurance market is flexible enough to permit us to buy what we want, and other employers to buy what they want. The important thing is to recognize that corporations have individualities and need freedom to work out the insurance programs which suit them best."

CATHOLIC HOSPITAL GROUP PICKS GOEBEL

Milwaukee, Oct. 1.—Msgr. Edmund J. Goebel, Milwaukee, Head of the Wisconsin Conference of Catholic Hospitals, has been chosen president-elect of the Catholic Hospital Association of the United States and Canada.

CONFERENCE STRESSES NEED FOR HEALTH DEPARTMENTS

Madison, Nov. 6.—The annual Health Conference sponsored by the State Medical Society and a large group of other organizations interested in health took place in Madison November 4 and 5 and drew a total registration of 298 persons.

The Wisconsin Public Health Council served as a co-sponsor this year, and arranged the second day of meetings. Dr. R. L. MacCornack, Whitehall, member of the council on medical service who is in charge of rural health matters, was chairman of the event.

After welcoming addresses by Dr. H. Kent Tenney, president of the society, Attorney General Vernon Thomson, in behalf of Governor Kohler, and Dr. MacCornack, Dr. Walter C. Alvarez, Chicago, consultant in medicine emeritus of the Mayo Clinic, spoke on the subject "What Makes Women so Nervous."

A panel discussion on the unsanitary conditions in our rural schools followed, with Orlo Miller, coordinator of school health with the State Department of Public Instruction, serving as moderator. Panel members included Harold L. Lautz, Madison District sanitary engineer; A. L. Buechner, Madison, supervisor of school building service of the department of public instruction, and Paul Burgess, school board member from Bristol.

Lautz said that a recent survey showed nearly 70 per cent of rural one-room schools have "potentially or actually unsafe water supplies, or none at all." About the same percentage have inadequate toilet facilities. Action to correct these things must come from the local health department or school board, he pointed out.

Buechner stated that these problems also apply to suburban schools. He said that standards set up by the state industrial commission for such things as heating, ventilation, lighting, equipment and sanitation are frequently violated in suburban schools.

Burgess remarked that more city-county health departments are needed to enforce proper regulations. He said he had great confidence in mothers' clubs as a means of forcing necessary action where local school boards fall down.

Mrs. Harold Wahlquist, Minneapolis, who has arranged health days in many Minnesota communities as an excellent means of health education, talked about how Wisconsin people can organize such days in their counties or towns.

—*Madison Capital Times photo.*

DR. R. L. MacCORNACK, right, chairman of the 1953 Wis. Health Conference, chats with Dr. W. C. Alvarez, Chicago, and Miss Edith Bangham, Madison, president of the Wis. Public Health Council.

Her audience later broke up into buzz sessions. One of these, led by Miss Edith Bangham, assistant state leader of home economics extension, discussed health day organization and community support. Mrs. Victor Falk, Edgerton, president-elect of the Woman's Auxiliary to the medical society, tackled the problem of health day program ideas.

A group which discussed means of financing health days was led by Miss Vivian Holland, statistician with the State Board of Health. William Sumner, Jr., editor of the Evansville Review, and his discussion group concentrated on the subject of health day publicity. A total of twenty-eight people declared themselves to be interested in staging health days in their own communities.

The male chorus of the University of Wisconsin Medical School, known as the Medichoir, prefaced the evening program with fifteen minutes of music.

Afterward, Dr. Robert C. Parkin, director of postgraduate medical education at the University of Wisconsin, served as moderator of a panel on cancer. The first speaker was Dr. Warner S. Bump, Rhinelander, who told something of the history of the American Cancer Society's fight against the disease. Dr. Herbert Willy Meyer, New York, talked of the clinical aspects of cancer, and Dr. Stanley P. Reimann, Philadelphia, spoke of the pathologist's role in the cancer fight. This forum was sponsored by the Wisconsin Division of the American Cancer Society.

(Continued on page 608)

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

Applicants for Treatment of Non-Service Connected Ills Must Answer VA Questions

Washington, November 5.—The Veterans Administration today announced that veterans seeking hospital treatment for non-service connected ailments will be asked to provide information concerning their financial status.

The VA emphasized that the additional information, which will be furnished in the answers to five questions, is designed to protect applicants and veterans generally from charges of "chiseling" on the government by signing a false statement of inability to defray the necessary expenses of hospitalization or domiciliary care.

Must Answer Questions

The questions to be answered by applicants are:

1. **What is the current value of your property both real and personal?**
2. **What is the current amount of your ready assets, in the form of cash, bank deposits, savings bonds, etc.?**
3. **If you own real property, what is the approximate amount of the unpaid mortgage or other indebtedness owed thereon?**
4. **What are your average monthly expenditures, including your mortgage payments and all other personal expenses including your expenses for your dependents?**
5. **What was your average monthly income for the last six months, from all sources?**

In its instructions to field stations in connection with the added questions on the application for hospitalization, VA said:

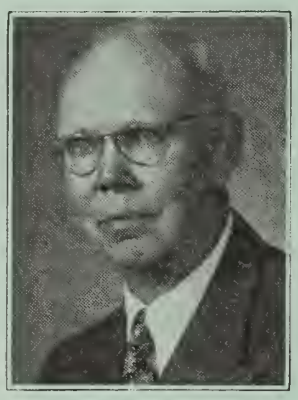
Focuses Attention

"Use of this addendum should cause each applicant for hospitalization to focus his attention on his financial status, and thereby give him a clearer understanding of the propriety of signing the oath of inability to pay. To assist him in determining his ability to pay, the applicant should, if and when practically possible, be given some indication of the probable length of required treatment.

"This addendum may be used in no way whatever to deny hospitalization to a veteran as the law specifically provides that 'the statement under oath of the applicant . . . shall be accepted as sufficient evidence of inability to defray necessary expenses.'

"The adoption of this addendum in no way changes or modifies the personal and confidential letter of March 27, 1953, in which the Chief Medical Director instructs all Managers and Area Medical Directors to 'report to the Administrator . . . all cases . . . which clearly indicate the statement as to inability to defray expenses of hospitalization is false.'

"No investigation of such cases will be made or requested at the local level, and no report of them will be made to any other government agency or official, except as authorized by Central Office."



DR. H. A. SINCOCK

Dr. Sincock Appointed to Hospital Committee

Madison, Oct. 28.—The State Board of Health has appointed Dr. H. A. Sincock, Superior, as one of five members of a new advisory committee required by statute to assist in the establishment of standards for hospitals necessary for the adequate care of hospitalized persons.

Other members of this committee are William L. Coffey, Milwaukee hospital administrator; Miss Grace Crafts, Madison nurse; Paul Bjerke, Eau Claire pharmacist; and Dr. W. R. Plater, Madison dentist.

After the standards are established and published, approval by the Board of Health shall be necessary prior to July 1, 1954, to maintain a hospital.

CONFERENCE STRESSES . . .

(Continued from page 607)

Opening speaker the second day of the conference was Dr. F. S. Crockett, Lafayette, Ind., chairman of the AMA's council on rural health. He said that health councils can contribute much to the improvement of medical care through helping communities to get doctors and establish clinics or hospitals. But, he pointed out, it is the responsibility of the community to keep a doctor when they get one, by trusting him with their major medical problems as well as their minor ones.

Crump Urges Education

Gordon Crump, editor of the Cambridge News, threw a joint challenge to the Wisconsin Public Health Council and the State Medical Society. He said that if everybody believes most cancer victims could be saved by frequent physical examinations, the councils and the physicians should get together to do some real education to save these lives. He urged formation of a joint committee representing health councils, physicians and press representatives for the purpose of starting a concentrated educational campaign against the preventable diseases.

Short summary talks about health projects which had been successfully carried out in their communities were given by representatives of four health councils.

Members of the Dane County Association of Health Councils talked about their mental health program, and representatives of the Outagamie County Health Council discussed their immunization project. Dr. Arthur P. Hayward, Wisconsin Rapids dentist, told about the formation of a dental health council in his city. Miss May E. Bryne, Balsam Lake, secretary of the Polk County Health Council, spoke on the subject of her group's school readiness program.

Dr. John S. DeTar, Milan, Mich., past president of the Michigan Health Council, urged establishment of community and county-wide health councils to take up such problems as heart, TB, cancer and polio drives; getting public health nurses, improving garbage disposal, getting a doctor to locate in the area, eliminating pollen producing plants, starting health departments, and taking advantage of chest x-ray facilities.

New Doctor Draft Regulations Base Rank Only on Experience

Madison, Nov. 10.—A long-awaited directive implementing the new physician "draft" law has been issued by the Department of Defense. It has several important implications for all physicians facing military service.

Highlights of the new directive follow:

1. Physical standards have been lowered so that all physicians are considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces.
2. **Physicians may receive up to three months' advance notice of their call into the armed forces—30 days' notice by Selective Service before their induction date, and 45 and 60 days between their induction date and their reporting for duty date.**
3. A physician's acceptance of a commission in the service of his choice will be conditioned on the actual needs of that branch of the armed forces. This is to prevent any one of the armed services from obtaining more than its share of medical officers.
4. **"Cut-off" dates for determining grades are eliminated and ranks are assigned on the basis of total years of professional experience since date of graduation from medical school. Internship is counted as professional experience. See accompanying table.**
5. Special registrants who are also regular registrants will be accepted for reserve commissions even though their call to active duty may be postponed indefinitely.

The directive provides for readjustment of grade for those already in service or in the active reserve, but not yet on duty. The following procedures have been established for adjusting grades of various categories of physicians:

A. **Any physician appointed to a reserve commission and now on active duty, who would have been entitled to a higher grade had the new directive been in effect at the time of his appointment, will be entitled to an adjustment of grade.**

B. **In the case of a reserve officer not yet on active duty, a reappointment or promotion will be made immediately prior to his being ordered to active duty.**

C. **Special registrants not yet commissioned will be commissioned according to their years of experience. This may indicate that certain physicians will find it to their advantage to delay acceptance of a commission until additional months of experience are accumulated.**

Selective Service has recently issued an order to local draft boards pointing out that physicians who are both regular and special registrants should not be inducted if they have applied for or have been accepted for commission.

Dr. Turner Takes Over Duties as Council Head

Chicago, Oct. 7.—Dr. Edward L. Turner, dean of the school of medicine and chairman of the division of health sciences at the University of Washington, Seattle, since 1945, has become secretary of the AMA Council on Medical Education and Hospitals.

He succeeds Dr. Donald G. Anderson, who left October 1 to become dean of the school of medicine of the University of Rochester.

Pharmacy Group Tells Its Platform for 1954

Washington, Oct. 1.—Washington headquarters of the American Pharmaceutical Association has laid down its 1953–54 platform, based on official action taken last month at its annual meeting.

According to the Washington Report on the Medical Sciences, the association stands as follows regarding matters related to medicine:

It wants a special conference of representatives of allied health professions "for the purpose of developing an interprofessional code of ethics based upon modern methods and facilities for supplying medical care to the public."

It seeks to have HEW Secretary Oveta Culp Hobby request the Food and Drug Administration to temper its publicity which, according to APHA, often conveys the impression that most druggists dispense barbiturates recklessly.

It favors a continuing of public health education by means of drug store posters, displays and the like.

Its committee on social and economic relations is to conduct a survey of voluntary health insurance plans with reference to their provisions for supplying drugs.

It went on record in favor of telephonic transmittal of codeine prescriptions.

It reaffirmed opposition to the operation of pharmacies in physician-owned clinics, and to the acceptance by physicians of kickbacks from the sale of drugs and appliances prescribed by them.

DETERMINATION OF RANK

The rank assigned to physicians called to active duty under the "doctor draft" will be based upon the number of years spent in appropriate professional activities subsequent to graduation from medical school and prior to date of appointment to a commission. The following schedule will apply:

Years Experience	Grade: Army and Air Force	Grade: Navy
Less than 4	1st Lieutenant	Lieutenant (JG)
4 or more but less than 11	Captain	Lieutenant
11 or more but less than 18	Major	Lt. Commander
*18 or more	Lt. Colonel	Commander

*Persons with 25 or more years of professional experience who have achieved national prominence as authorities in their particular specialty may be appointed in the grade of colonel in the Army or Air Force or as captains in the Navy.

DR. KASTEN IS ELECTED HEAD OF CONFERENCE

St. Paul, Minn., Nov. 1.—Dr. H. E. Kasten, Beloit, was elected president of the North Central Conference at its meeting here today.

The conference includes representatives from Wisconsin, Minnesota, Iowa, North and South Dakota, and Nebraska.

The conference went on record as favoring the Bricker amendment. It also passed a resolution expressing approval of the transfer of the health and hospital facilities of the Bureau of Indian Affairs from the Department of the Interior to the United States Public Health Service.

This proposed transfer has already received the endorsement of the Association of State and Territorial Health Officers and the Governors' Interstate Council on Indian Affairs.

Dr. Joseph C. Griffith, Milwaukee, immediate past president of the State Medical Society, was chairman of the resolutions committee.

Other officers elected at this meeting were Dr. George Earl, St. Paul, president-elect, and Mr. R. R. Rosell, St. Paul, secretary.

Otis Becomes President of National Hospital Planning Agency Group

Madison, Oct. 30.—Vincent F. Otis, head of the hospital division of the State Board of Health, was elected president of the Association of Hospital Planning Agencies at the annual convention in San Francisco in September.

He has previously served as vice-president, a member of the board of directors, and chairman of various committees.

This association is composed of state and federal planning agencies and voluntary health organizations interested in the field of hospital survey, planning, and construction and licensure.

It promotes the development of comprehensive hospital programs which raise the standards of hospital care and provide for the development of services within the states. It meets annually in conjunction with the American Hospital Association.

DR. H. E. KASTEN

DR. H. M. COON

Blue Shield Association Releases 1952 Figures

Chicago, Oct. 15.—A total of 26,632,513 persons were enrolled in Blue Shield plans in the United States, Puerto Rico, Hawaii and Canada at the end of last June.

These figures have been released by the Chicago office of the National Association of Blue Shield plans.

The percentage of those covered in the United States, Puerto Rico and Hawaii is 18.11, while the Canadian percentage is 11.47.

Blue Shield plans are now in operation in 41 of the 48 states, the District of Columbia, and eight Canadian provinces. Delaware leads with the percentage covered —62.12 per cent of its population. Second is the District of Columbia with 48.23 per cent, and next is Michigan with 45.26 per cent.

Coon, Sincock Placed on Hospital Council; Coon Named Chairman

Madison, Oct. 26.—Dr. H. M. Coon, superintendent of the University Hospitals, Madison; and Dr. H. A. Sincock, Superior, have been reappointed to the advisory hospital council to the State Board of Health, which assists in the development of the Hill-Burton hospital program in Wisconsin.

Dr. Coon, who is chairman, has served on this council since its inception.

Other reappointments and the fields they represent are Mrs. Otto Falk, Milwaukee, (consumers of hospital service); Paul Bjerke, Eau Claire, (pharmacy); and Dr. W. R. Plater, Madison, (dentistry).

Other members of this council are John W. Tramburg, Madison, (welfare); Miss Grace Crafts, Madison, (nursing); Dr. E. R. Krumbiegel, Milwaukee; Fred Proctor, Elkhorn, (agriculture); Leigh Hunt, Milwaukee, (architecture); Mrs. John Ramsay, Peshtigo, (consumer); Herbert Vonier, Milwaukee, (labor); William L. Coffey, Milwaukee, (hospital administration); and Dr. Carl N. Neupert, Madison, representing the State Board of Health.

The American Hospital Association honored Dr. Coon at its recent meeting in San Francisco by electing him a trustee of the organization. He will serve a three-year term.

Mrs. Wahlquist to Be Heard on WHA Saturday, Dec. 5

Madison, Nov. 5.—When Mrs. Harold Wahlquist, Minneapolis, was in Madison for the Wisconsin Health Conference, she was asked to do a tape-recorded program with Mrs. Aline Hazard, home program director of Radio Station WHA.

Her program will be heard Saturday, December 5, at ten o'clock in the morning.

Mrs. Wahlquist is a former president of the Woman's Auxiliary to the AMA and has a wide acquaintance among Wisconsin doctors' wives who may wish to listen to her program.

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

History

This 17-year-old girl was first admitted to the University Hospitals with a febrile illness characterized by migratory polyarthritis with intermittent red, hot, swollen, and tender joints in the fingers, wrists, elbows, shoulders, knees, ankles, and hips. The past medical history revealed that she had had recurrent tonsillitis before tonsillectomy. Her present illness cleared temporarily after tonsillectomy, only to recur. The systemic review revealed a transient precordial pain approximately 18 months before admission, and two weeks before admission a pleuritic chest pain on the left, followed by a nonproductive cough, had developed.

Physical Examination. Physical examination revealed a thin, chronically ill, pale girl. Funduscopic examination revealed a large hemorrhage between the disk and the fovea in the right eye. The pharynx was slightly reddened, and large lymph nodes were palpated in both axillae. There was percussion dullness at the left base with decreased tactile and vocal fremitus and decreased breath sounds in this area. The lower border of cardiac dullness was 9.5 cm. left of the midsternal line. An apical systolic thrill was present, as well as a grade III apical systolic murmur and an aortic systolic murmur. The mitral first sound was split. The pulmonic second sound was greater than the aortic second sound. The blood pressure was 110/50. On deep inspiration the tip of the spleen was palpable 1 cm. below the left costal margin.

Laboratory Studies. On repeated samples of urine, laboratory studies consistently revealed albumin, white cells, red cells, and casts in the uncentrifuged specimen. The hemogram revealed 7.9 Gm. of hemoglobin with 2,030,000 red cells and 3,650 white cells, of which 50 per cent were filamented neutrophils, 9 per cent nonfilamented neutrophils, 3 per cent juveniles, 1 per cent myelocytes, 34 per cent lymphocytes, and 4 per cent monocytes. The leukopenia persisted throughout the hospital course. Serology and routine agglutinations were negative. Hanger's test was 3 plus. The total serum proteins were 6.5 Gm., with 2.9 Gm. of albumin and 3.6 Gm. of globulin. The prothrombin time and thymol turbidity were normal. The erythrocyte sedimentation rate was 10 mm. per hour, corrected with a hematocrit level of 22 per cent. Chest x-ray showed pleural effusion on the left.

Course. Six initial blood cultures revealed no significant growth. However, the patient was started on 1,200,000 units of penicillin daily. After several days, one of the blood cultures taken before the onset of therapy was reported as positive for Streptococcus viridans. The patient became afebrile on penicillin therapy, which was continued for a total of six weeks. Subsequent ambulation produced a febrile course with temperatures up to 104 F. Repeated blood cultures and penicillin therapy were then started again. During this therapy an erythematous rash appeared over the face, chest, and back. Because of this, antibiotics were discontinued, and the rash cleared rapidly. Cortisone therapy was started at 200 mg. a day. The patient responded for the first five days and then a temperature of 104 F. developed. In blood cultures at the height of the fever, pneumococcus type 17 was found. At this time a chest x-ray revealed that the pleural effusion had cleared, leaving partial atelectasis of the right upper lobe and pneumonic consolidation. Penicillin was started again, and the temperature fell to normal. Numerous blood cultures thereafter were negative. She had numerous blood transfusions during hospitalization. At the time of discharge approximately eight months after admission she was feeling well.

Second Admission

When the patient was re-examined approximately 12 months later, the results of cortisone therapy seemed satisfactory. She was advised to return in two months, at which time she had recurrent fever, joint pains, a slight rash over the forehead and across the bridge of the nose, and a dull ache which had been present in the left hypochondriac region.

From the University Hospitals and University of Wisconsin Medical School.

Laboratory Studies. The laboratory results at this time revealed a white blood cell count varying between 4,000 and 5,600 with the lymphocyte count ranging between 33 and 47 per cent. The total serum protein was 7.8 mg. with 4.4 Gm. of albumin and 3.4 Gm. of globulin on one test and 8.05 Gm. with 3.3 Gm. of albumin and 4.75 Gm. of globulin on another occasion. Multiple blood cultures were negative. Urinalysis findings had not changed since the previous admission.

Course. Cortisone therapy was continued, and she was finally discharged on 50 mg. of cortisone daily with instructions to increase the dosage to 75 mg. or 100 mg. daily if she had a recurrence of symptoms.

Third Admission

Eight months later she returned to the hospital stating that two weeks earlier she had noted gradual onset of prickling sensations in her legs which eventually reached the waist. Coincidentally, she noted weakness of her legs which become so severe that she was not sure if she could walk. Urinary difficulty was experienced; she could not empty her bladder. Constipation became very severe. A cough had been noted during the three days before hospitalization. Unless she took 75 mg. of cortisone daily, she noted a fever every day up to 101 F. She stated that her skin rash was much worse than it had been before exposure to the April sun.

Physical Examination. The physical examination revealed a maculopapular rash involving the face, marked thinning of the hair, and heavy coating of the tongue. Transient rhonchi were noted occasionally on the right. The liver was felt 2 cm. below the costal margin, and the spleen was 1 cm. below. The reflexes were generally hypoactive. There was considerable loss of sensation to pinprick in the perianal area, but otherwise there was no change in sensations.

Laboratory Studies. The laboratory studies at this time revealed albumin in the urine, persistent leukopenia, and normal prothrombin time. Serum proteins were 7.1 Gm. with 3.6 Gm. of albumin and 3.5 Gm. of globulin. A lumbar puncture revealed the cerebrospinal fluid protein to be 175 mg. per cent, sugar 39 mg. per cent, and chlorides 106 milliequivalents per liter. There were 16 white cells, of which 14 per cent were polymorphs and 86 per cent lymphocytes. The gold sol was 5555432100. The serology was negative. Queckenstedt's test was negative. The patient's mental state became quite confused, and after a convulsion she became markedly worse.

Course. Therapy of 300,000 units of duracillin twice a day was started to ward off infection, and ACTH was given by continuous intravenous drip. Duracillin and dosage of 3 Gm. of para-aminobenzoic acid three times a day was started. She became steadily worse with continued fever, developed generalized twitchings, and died.

Clinical Discussion

Dr. J. K. Curtis: Doctor Angevine has chosen an ideal case for discussion this afternoon. This 17-year-old girl suffered a prolonged illness. Since she was admitted three times to this hospital, there was ample opportunity to observe the progress of her disease in great detail. Consequently, a number of clinical facets became apparent which are worthy of comment.

The history of transitory precordial pain approximately 18 months before admission combined with the migratory polyarthritis temporarily benefited by tonsillectomy makes one think immediately of rheumatic fever. At any rate, one would tend to classify her illness in the collagen disease group. It should be pointed out that the removed tonsils should be carefully cultured and the microscopic sections studied, for it is not unusual to find tonsils harboring chronic foci of infection such as Streptococci. Microscopic sections may occasionally reveal unsuspected tubercles, blood vessel diseases, lymphoma, etc. The patient entered the hospital with the complaint of pain in the chest for two weeks, associated with a nonproductive cough suggesting pleurisy.

This girl appeared thin and chronically ill and apparently was febrile. In the right fundus a large hemorrhage was noticed which may have been on the basis of an embolic phenomenon, vascular disease, or blood dyscrasia. It is interesting that large lymph nodes were palpated in both axillae and that the spleen was felt 1 cm. below the left costal margin. These findings are rather unusual in acute rheumatic fever. It puts us on guard for complications or other related diseases. There were signs of fluid in the left pleural cavity. There was auscultatory evidence that the mitral valve and possibly the aortic valve were involved in the disease process.

Throughout the course of her illness this patient consistently had abnormal urinary findings: albumin, white cells, red cells, and casts in the uncentrifuged specimens. Blood studies revealed a rather profound anemia, and she had a leukopenia without an eosinophilia. The Hanger's test was 3 plus, suggesting a "sick liver." There was an inversion of the albumin-globulin ratio. The erythrocyte sedimentation rate was not striking. The findings so far then have tended to lead us away from our original consideration of acute rheumatic fever. The physicians in charge of the case suspected subacute bacterial endocarditis, and several blood cultures were taken. Apparently they were so confident of their diagnosis that they began penicillin therapy. Their good judgment was rewarded by a positive culture for Streptococcus viridans which grew out in a few days. However, the usual six weeks' course of penicillin did not establish a cure, because fever developed once more and the patient was placed on penicillin. At this time an erythematous rash over the face, chest, and back developed.

At this point we must decide whether the rash was due to a penicillin sensitivity or whether we have here the first skin manifestations of lupus erythematosus. There are many physicians who believe that penicillin sensitivity may be one of the factors in producing lupus erythematosus. This is suggested by the fact that there have been increasing numbers of these patients since the advent of antibiotic therapy. Secondly, L. E. cells have been demonstrated in a number of patients exhibiting penicillin sensitivity. In this particular patient, however, one is inclined to believe that the disease process preceded the administration of penicillin during this admission. Cortisone therapy opened the gate for another infection. This time pneumococcus type 17 was cultured from the blood. This infection was successfully combatted with pencillin and a number of blood transfusions. I am sure her physicians breathed a sigh of relief when she was finally able to leave the hospital eight months after her entry. At the time of discharge I suspect they had settled on the diagnosis of disseminated lupus erythematosus.

Let us review for a moment the evidence in support of this position. First, the patient was a young girl with a chronic illness involving the joints and the serous membranes. She had a hemorrhagic manifestation in the fundus of the eye. The lymph nodes and the spleen were enlarged. There was evidence of fluid in the chest and signs of valvular heart disease. There is no question, then, that her disease was disseminated, and furthermore, the urinalysis showed the kidneys to be extensively involved. The classical blood picture in lupus erythematosus is a normocytic anemia, and a leukopenia occurs in at least half of the cases. More rarely there may be a hemolytic type of anenia, and occasional cases have thrombocytopenia. Serum protein changes also occurred in this disease. It is time now to ask Doctor Meyer whether L. E. cells were found in this patient.

Dr. O. O. Meyer: Yes, typical L. E. cells were found both in the bone marrow and in the peripheral blood. Her serum was not tested against normal bone marrow cells, which is another method of demonstrating the L. E. phenomenon.

Doctor Curtis: I would like to ask Doctor Meyer whether the finding of L. E. cells makes a positive diagnosis of lupus erythematosus.

Doctor Meyer: L. E. cells are occasionally reported in diseases other than lupus erythematosus, but in this particular case it would appear to clinch the diagnosis.

Doctor Curtis: The second admission of this patient was advised because of a relapse in spite of cortisone therapy. This time the patient had recurrent fever, joint pains, and a slight rash over the forehead and across the bridge of the nose. This was apparently the first time that the typical butterfly lesion in the skin had been noted. The patient also had pain in the left hypochondrium, suggestive of splenic infarct. The laboratory investigation revealed no additional information. She was discharged and continued on cortisone therapy.

The patient entered the hospital for the third time with neurological manifestations. She had noticed in her legs a prickling sensation which eventually reached the waist. There had been weakness in the legs and difficulty in walking, and she also noticed trouble in emptying her bladder and the onset of constipation. She was febrile. The rash had reappeared upon her face.

Dr. S. A. M. Johnson: It should be emphasized that exposure to the April sun aggravated the skin condition. Many of these patients are particularly sensitive to sunlight.

Doctor Curtis: Yes, that is a good point, Doctor Johnson. We now have the additional finding of thinning of the hair also seen in lupus erythematosus. The liver has become enlarged, and the spleen is still palpable. The reflex changes are not helpful in localizing the neurologic lesion, but we are told that there is loss of sensation to pinprick in the perianal area, suggesting a low cord lesion. In lupus erythematosus one may have embolic phenomena, diffuse nervous system involvement by endarteritis and thrombotic involvement of the blood vessels supplying the nervous system. The gradual onset of her disability suggests that the latter lesion is most likely to be found in this case. The spinal fluid reveals a high protein content and a slight increase in white cells, mostly lymphocytes. The paretic-type gold curve is due to alterations of the proteins. The patient's condition apparently deteriorated rapidly; she became confused and died following a convulsion.

We are now left with the problem of determining the cause of her death. We have strong evidence that her nervous system was involved, but the major lesion seems to have been in the spinal cord. A nonspecific diffuse encephalitis may lead to convulsions and death. Throughout her long illness we had been aware of the fact that her kidneys were severely involved, and the terminal convulsion may have been on a uremic basis. However, at no time has mention been made of an elevated nonprotein nitrogen or creatinine. Occasionally with cortisone therapy profound electrolyte changes may develop, but this patient tolerated cortisone treatment well throughout many months. We are given no evidence that her electrolyte pattern was severely deranged. I am inclined to believe that she died of an overwhelming infection. The patient was febrile and was given penicillin as well as ACTH. We know that she had already gone through septicemia with Streptococcus viridans and pneumococcus type 17. It is quite possible that the terminal illness was on the basis of an organism resistant to penicillin. We must not forget also that tuberculosis sometimes becomes activated by administration of ACTH and cortisone. It is possible that she had a miliary dissemination involving the meninges as well.

My final diagnosis is disseminated lupus erythematosus. We will expect to find involvement of the blood vessels, skin, pleura, possibly pericardium, and endocardium; enlargement of the liver; splenic infarcts; classical lupus involvement of the kidneys; and thrombotic lesions in the central nervous system, particularly the lower cord. It will be of some interest to learn whether the prolonged cortisone therapy modified the lesions usually seen in lupus erythematosus. Her terminal illness may have been due to an overwhelming septicemia, possibly on a tuberculous basis.

Necropsy Findings

(University Hospitals 52:144)

Dr. P. G. Piper: No rash was present over the face at the time of necropsy. Bilateral pleural adhesions were found, and the lungs revealed a bilateral confluent bronchopneumonia. The spleen contained multiple infarcts. The heart and kidneys had focal areas of inflammatory change with actual necrosis within the kidney parenchyma. Scattered clusters of cocci found in the heart and kidneys were identified on culture as Staphylococcus aureus.

An examination of the brain was essentially normal except for focal acute vasculitis and perivascular demyelinization. Some vessels revealed fibrinoid change within the wall.

The cord presented a fusiform-like lesion in the lumbar area which measured 3.0 by 1.5 cm. Similar vascular lesions involving the meningeal vessels were found as described above with the additional presence of thrombi, one of which was recanalized. Myelomalacia of the posterior funiculi adjacent to the involved vessels was quite apparent.

Since no source could be found for embolism and since a high incidence has been reported associated with disseminated lupus erythematosus without demonstrable evidence for such lesions, it is considered to be compatible with previously described cases.

The cause of death was a fatal systemic Staphylococcus septicemia. In the absence of characteristic findings of L. E. which could be attributed to the long regime of cortisone therapy, it was felt that the vascular lesions both involving the meninges of the brain and adjacent to the cord lesion were the direct result of an L. E. focal vascular involvement of the cord associated with lupus erythematosus resulting in myelomalacia of the spinal cord and paralysis.

Community Self-Appraisals Are Beneficial

As It Looks to Your State Board of Health

MANY of our Wisconsin communities are developing considerable interest in appraisals by the citizens themselves, by people outside the community, or by the two groups working together, with the citizens participating in the appraisals themselves but securing guidance from professional people as the study proceeds. Some communities are interested in rather limited surveys, such as knowing what the immunization status of its youngsters is, learning about the nutritional needs of children, determining what the dental caries picture is, or finding out whether the milk supply of the community meets grade A standards. Other communities may be interested in knowing practically everything about themselves that may be included under the broad term "public health." It may cover administrative phases; environmental sanitation with its many facets; preventable disease control, including the chronic disease picture; maternal and child health, including school health, dental health, and nutrition; accidents and safety in the home and farm, in industry, and on the highways.

Most of these appraisals are begun by citizens wanting to get at the facts. As they sit around the table discussing the results, they are motivated to do something about the needs of their community based on the facts uncovered, and they proceed to stimulate public interest and action by official bodies.

A great variety of technics may be employed to secure the facts in the first place, including questionnaires mailed to selected groups, questionnaires for a house-to-house or farm-to-farm canvass, talks with various officials, study of many and varied types of records, etc.

Generally, the community appreciates professional guidance in determining the scope of the appraisal, phrasing the questions and tabulating and analyzing the answers, and drawing up conclusions and recommendations.

Some may say that a lot of time and effort goes into such appraisals and that very little is actually accomplished. With the former statement we agree fully, but we would like to point out some of the accomplishments in communities that have engaged in this work.

Any number of communities have had their official bodies act favorably on passing grade A milk ordinances. One in particular that we have in mind had considerable opposition but, as a result of citizen participation, the ordinance was passed without a dissenting vote, giving evidence of the educational possibilities inherent in the appraisal method.

In one area, as a result of studies of food habits of boys and girls (limited to fourth graders because it was felt they would report accurately without coloring the picture on the basis of what they knew they *should* be eating), four teacher-training meetings were held to help these teachers take advantage of the opportunities they have to improve everyday food habits.

In other communities one or more of the following have been accomplished: a driver training course has been started; a centralized blood bank has been established; more educational work in the field of mental health has been stimulated; a school health program has been improved by eliminating relatively unproductive features formerly carried out and replacing them by more modern ones; and work has been started on improving conditions in rooming houses by drafting a new ordinance on them. There has been an increase in the number of parents taking children to dentists for treatment. X-rays are being taken of all employees in a general hospital. The public schools are initiating a health curriculum study. Care of city dumps has improved. A visiting nurse association has been created. A chest x-ray program for school personnel has been initiated. Readiness-for-school programs utilizing physicians' services in their own offices have been improved. Fluoridation programs have started in many communities. In one community four different safety groups decided to amalgamate to form one effective group.

Fortunate is the community that has the type of leadership that arranges to have wide citizen participation in these appraisals for, in the last analysis, it is upon the leader-

ship and understanding of the local community that the health and welfare of its citizens must inevitably depend. Wide citizen participation means representation from all official and voluntary health agencies in the area; professional societies, clubs, associations, and organizations having an interest in health; consumer groups; management and labor groups; all nationality groups; men and women, the young as well as the not so young; and in many cases rural as well as city folk. If the rural area is to be included, then there should be representation from all townships. Such wide citizen participation will tend to assure understanding and, subsequently, action.—ALLAN FILEK, M.D., *Director, Section on Local Health Administration.*

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:30 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WCAN	Milwaukee	Sunday	6:45 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:45 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	5:45 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	4:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Tuesday	7:15 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Saturday	10:15 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:00 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Minutes of the Council Meeting, Land O'Lakes August 1 and 2, 1953

1. Call to Order

The Council was called to order by Chairman Arveson at 10:00 a.m., Saturday, August 1, at Land O'Lakes.

2. Roll Call

Councilors present were Doctors Costello, Hill, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, and Chairman Emeritus Gavin (Sunday only).

Also present were President Griffith; President-Elect Tenney; Speaker Forkin; Vice-Speaker Fons; Treasurer Weston; Doctors W. D. Stovall and D. H. Witte, Delegates to the American Medical Association; Dr. J. M. Sullivan, Chairman, Committee on Public Policy; C. N. Neupert, State Health Officer (Saturday night and Sunday only); and Mr. Allen J. Strang, architect (Saturday night only).

Staff members present were C. H. Crownhart, secretary; Earl Thayer, director of public information; Byron Ostby, field secretary; Robert B. Murphy and S. E. Gavin, Jr., legal counsel; and Miss Joan Pyre and Miss Jean McGruer of the Society's office.

3. Approval of Minutes

On motion of Doctors McCarey–Heidner, carried, the minutes of the February 28–March 1, 1953, Council meeting, as published in the June 1953 *Wisconsin Medical Journal*, were approved.

4. Report of Commission on Prepaid Plans

Doctor Dessloch, Chairman of the Commission, presented its report for the year ending June 30, 1953, and on motion of Doctors Ekblad–Kasten, carried, the report was approved for submission to the House of Delegates. This statement will be contained in the report of the House, which will be published in the December issue of *The Wisconsin Medical Journal* as well as in the Delegates Handbook.

5. Report of Commission on State Departments

Mr. Crownhart reviewed the report of the Commission on State Departments and its various divisions as to organization of its activities and projects. On motion of Doctors Heidner–Hill, carried, the report and its recommendations were approved by the Council for submission to the House of Delegates. It will be published in the December Journal as well as in the Delegates Handbook.

6. Report of Committee on Blood Banks

The Council reviewed the report of the Committee, which was concerned primarily with the distribution of gamma globulin and the problems of mass immunization for polio. It was recommended by the Committee that county medical societies could be of assistance in the problems by developing suggested plans for conducting a local mass immunization, and that county officers work with the district councilor in the event of a mass immunization in neighboring counties, and finally, that polio committees be established in county societies where such committees do not already exist.

Doctor Stovall emphasized to the Council the importance of the program and said that approval of the recommendations "means contracting for a very difficult community responsibility and job."

On motion of Doctors Galasinski–Heidner, carried, the recommendations of the Committee were approved, the report to be submitted to the House of Delegates.

7. Recommendations of Council on Medical Service

The Council on Medical Service conducted a survey of 485 high schools in Wisconsin as to their interest in the availability, on a loan basis, of tapes for the March of Medicine programs. Ten tapes have been selected on subjects which would be of interest to such a group. The proposal appears to be of great interest, and the Council on Medical Service recommends the allocation of $200 from within the current budget for the expense of a trial run for one year.

On motion of Doctor Kasten, variously seconded and carried, the Council on Medical Service was authorized to initiate the project.

8. Committee on Military Medical Service

Doctor Weston, Chairman of the Committee, summarized the military situation with regard to physicians in the various priority classes under jurisdiction of Selective Service as of June 30, 1953. It was reported that for the most part reserve officers who held commissions before 1950 have all been recalled and are now completing their tours of military duty.

As to the Doctor Draft Law, Doctor Weston said that the complete revision of the law and its extension to July 1955 may substantially change the future of military calls for physicians, and that details of its administration are being developed in Washington for the use of state advisory committees.

Doctor Weston thanked the Councilors and other physicians who have served in advisory capacities to the Committee for their invaluable help and support.

9. Special Order—Meeting with Board of Health

Councilors and officers recessed at this point to make a special tour of the facilities and program of the Lake Tomahawk State Camp, a rehabilitation

center for the tubercular. Doctors Gavin, Neupert, and White and Mr. Leonard Heise, Director, addressed the group.

10. Historical Committee

This is a special committee of the Council. In view of previous action taken to organize the Section on Medical History, the secretary recommended that the special committee can now be abolished.

This recommendation was approved by the Council on motion of Doctors Bell–Galasinski, carried.

11. Action of the AMA on Osteopaths and Osteopathic Training

A report of the special committee of the American Medical Association on the subject of osteopathy and medicine was submitted to its House of Delegates in June 1953. A copy of that report and recommendations on it by the Board of Trustees were circulated by mail to the Council in order to determine whether it desired to consult the House of Delegates of the State Medical Society in October.

It was recommended by Doctor Gavin, Delegate to the American Medical Association, and approved by the Council, that the matter be laid over until its May 1954 meeting.

12. Report of Wisconsin Veterans Medical Service Agency Operating Committee

The report of this committee was circulated to the Council before its meeting and, on motion of Doctors Bell–Bernhart, carried, approved for submission to the House of Delegates. The statement will be contained in the report of the House, to be published at a later date.

13. Veterans Administration and Its Attitude on Services of the Certified Public Accountant

The Veterans Administration has suggested that audit by a certified public accountant of records of the Service Agency, which has been provided by the State Medical Society, is unnecessary, and that this administrative cost could be eliminated in future billings to the Veterans Administration for reimbursement of costs. In a proposed reply to this suggestion the Secretary expressed disapproval of it, saying that the "Society would be derelict in any over-all responsibility to its membership, to participating physicians, and to the government, were it to fail to properly audit these matters."

The secretary requested approval of the proposed reply, and it was granted on motion of Doctors Ekblad–Heidner, carried.

14. Review of Council Action, November 1952 Meeting

The Council, on recommendation of the Council on Scientific Work, suspended the by-law provision contained in Chapter II, Section 2, limiting the length of papers prepared by Wisconsin speakers to 20 minutes at the time of the Annual Meeting.

The question before the Council was whether it wished to refer the subject to the House of Delegates for action.

It is recommended to the House of Delegates, on motion of Doctors Kasten–Heidner, carried, that this section of the by-laws be abolished as obsolete.

15. Educational Membership

The subject of a special membership, with lower dues, for those physicians engaged in full-time teaching in the basic sciences and not engaged in the active practice of medicine was presented in the report of the Interim Committee at the May Council meeting, and held over for discussion in July. A recommended resolution to implement this membership was presented and is contained in the minutes of the May meeting.

After considerable discussion, the resolution was adopted, on motion of Doctors Galasinski–Ekblad, carried, for referral to the House of Delegates with the recommendation that a new section be created in Chapter VIII of the By-Laws to provide for an educational membership.

16. Report of the Interim Committee

A number of routine details were considered by the Interim Committee at its meeting July 31, including a review of a bond on Society employees, insurance on the building, and action to release copies of the annual audit to the bonding company.

The Committee recommends that the Council establish as a second regular order of business at future Council Meetings a call on each Councilor present to state any matter he may wish placed on the agenda of future meetings, or considered at the current meeting, if it is urgent.

Second, the President of the American Medical Association will be the honored guest of the Society on Monday, October 5. The Interim Committee recommends that this event be arranged so that the entire House of Delegates, officials of the Auxiliary, and invited guests representing other professional groups can be present.

Third, Dr. R. G. Arveson discussed the operations of the Washington office of the American Medical Association. His recommendations were that that office be further implemented by the employment of such individual or individuals as would be in constant Congressional and governmental contact. The Interim Committee recommends to the Council that a communication be addressed to Dr. Gunnar Gundersen, as a member of the Board of Trustees, urging their further consideration of this matter.

Fourth, an Employees Mutual Benefit program, in which there is limited choice of physician, was reviewed by the Committee, which asks that the matter be referred to the Commission on Prepaid Plans for study and report to the Council, with particular reference to the matter of free choice.

Fifth, the Secretary was instructed to set the wheels in motion in an effort to eliminate American Medical Association requirements regarding waiver of dues only for the first five years after graduation from medical school.

On motion of Doctors Kasten–McCarey, the report of the Committee was approved and adopted as a whole.

17. Building Report

A special order of the meeting after dinner Saturday evening was presentation of preliminary plans of the new building to the Councilors and officers and their wives by Mr. Strang, architect. He showed slides of a model of the building, the location itself, and the building drawings. There was discussion of the slides as presented and opportunity for questions to be answered by the architect.

After this presentation, the Councilors and officers went into formal session, and the Secretary reported on the ownership and operation of the new building. The report dealt with present minimum building requirements, cost of the proposed building, alternate plans of financing, and his recommendations.

Under the proper formula for financing the building, in which it is necessary to take insurance and investment laws into account, it was indicated that funds presently available would not be adequate to finance the building required.

Chairman Arveson asked for the opinion of each member present, and there was long and detailed discussion of the report and its recommendations. It was recommended that building plans be temporarily deferred to permit an additional build-up of assets but that the architect continue to develop working drawings and detailed specifications and that he be paid for services rendered to date; further, that authority be granted the Secretary to secure additional office space in rented quarters or to make longer hour use of present facilities if it appears necessary; that newly developed activities and projects be carefully scrutinized by Councilors and officers and their administrative impact considered, in order to keep expenses down. Finally, the Secretary stated that he was opposed to any efforts to secure the additional funds necessary through solicitation of donations or investment of individual physicians in secondary securities, or through a dues increase. He emphasized the importance of sound financing and sound planning throughout the project.

It was moved by Doctor Dessloch, seconded by Doctors Kasten and Heidner, and carried, that the Council adopt the report and recommendations of the planning committee and the Secretary. In a roll call vote there was unanimous approval by the Councilors present.

18. Legislative Report

Dr. J. M. Sullivan, Chairman of the Committee on Public Policy, reported on a discussion with members of the Wisconsin Pharmaceutical Association in which that association expressed its interest in entering into an educational campaign to promote cooperation between the pharmaceutical and medical professions. It was further recommended that a liaison committee representing members of each group be organized to set up a program or plan for conducting such a campaign.

Doctor Sullivan also discussed the results of the recent legislative session and commended the staff and physicians for their assistance and work in accomplishing the results.

On motion of Doctors Bell–Fox, carried, the report and recommendations of Doctor Sullivan were approved by the Council, and subsequently the Committee on Public Policy was appointed to serve in a liaison capacity with a similar group representing the pharmacists.

19. Report of Secretary

The Secretary reported that with the approval of the Interim Committee the staff will prepare a calendar, to be made available in the fall, setting up principal meeting dates for the ensuing 12 months. The schedule will include dates for the Council, Interim Committee, Commission on State Departments, and Commission on Prepaid Plans and its committees, and will be a printed calendar in chart form. This will better enable members of the various committees to make necessary arrangements in advance.

Mr. Crownhart discussed with the Council some of the personnel problems in the headquarters office. He said an effort would be made to re-examine some of the personnel procedures and to reclassify jobs on a point basis so that there is a more clear description of them in relation to work specifications and pay levels.

20. Retirement Program—Society Employees

The Audit and Budget Committee and the Committee on Executive Salaries reported their studies of a retirement program for Society employees and adjustments necessary in certain executive salaries.

Doctor Dessloch, Chairman, recommended that effective July 1, 1952, four executive salaries, those of the director of public information, the comptroller, the assistant Secretary, and the claims director, be increased a total of $3,075 for the balance of the year. It was further recommended that the matter of a parallel comparison between an insurance-funded program and a Society-operated program for retirement of employees be submitted at the next meeting of the Council, with decision at that time permitting completion of one or the other effective January 1, 1954.

On motion made, variously seconded and carried, the report and its recommendations were approved.

21. Adjournment

The meeting adjourned at 11:30 a. m., Sunday, August 2, 1953.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M. D.
Chairman of the Council

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 NOVEMBER 1953 Number 11

COUNCIL ON SCIENTIFIC WORK

J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
L. G. Kindschi—Monroe
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS

THE COUNCIL

W. H. Costella—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Marinette
R. E. Garrison—Wisconsin Rapids
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
J. C. Griffith—Milwaukee
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MRS. H. B. TENNEY, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Masan—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Ray T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'— 1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Free Choice of Physicians

[The following article by Dr. M. O. Boudry of Waupaca is very timely and deserves serious reading by every member of our Society. Doctor Boudry has special reason to comment on this subject because of his experience with the Public Welfare Department in his area.

As Doctor Boudry suggests, insurance companies, government agencies, and welfare groups are already thinking in terms of where to direct the patient. Since a large proportion of the doctor's practice is becoming concerned with insurance plans, etc., it behooves all of us to consider Doctor Boudry's article very seriously.—*J. M. Sullivan, M. D., Editorial Director*]

To define the term "free choice of physician" is to review in part the rules that govern our civil rights. To be free we must have the privilege to decide and choose. The physician-patient relationship in the United States is founded on this right. It establishes an honest, satisfactory, counseling, friendly patient-doctor status. This free choice is not to be confused with free service, nor is it to mean the freedom to run from one doctor to another at someone else's expense.

To have a family doctor by free choice is to have the services of a physician in the immediate vicinity available night or day. This distance in miles is never great, but it may cross city, county, or state boundaries. At present this state has welfare directors thinking in terms of "free choice of any physician in their county," and advocating strongly that patients go to the doctor living nearest them, as transportation costs are now an item of expense.

The former statement is contradictory, asserting freedom while imposing arbitrary geographic limitations upon that freedom. Such restriction of free choice is a serious denial of civil rights, and, in the case of patients living outside the central area of a county, it is not an economic arrangement.

When insurance companies, government agencies, or welfare groups defray the expense of medical care, more thought and guidance than usual are necessary to adopt the proper rules and regulations governing medical aid. This is the duty of an informed medical and legal personnel with more than local interest; such definition of rules and regulations by competent authorities is an urgent necessity. All welfare groups, especially Wisconsin county units, need to comprehend thoroughly the term "free choice of physicians," as it is the foundation of good medical service.

535 North Dearborn Street, Chicago 10, Illinois

RICAN MEDICAL ASSOCIATION news notes

NOVEMBER 1953

AMA news written especially for use in state medical journals

Voluntary Health Insurance Shows Gains

In all parts of the country, the American people voluntarily increased their protection against the unexpected costs of hospital, surgical, and medical care to new heights in 1952, reports the Health Insurance Council in its current annual survey of accident and health coverage in the United States. The AMA's Council on Medical Service is distributing copies of the report to medical schools, teaching hospitals, and state and county medical societies.

Organizations contributing data to the Insurance Council's report include insurance companies, Blue Cross, Blue Shield, and various other independent plans sponsored by business and industry, employee benefit associations, and private group clinics.

Statistical highlights of the report: Nearly 92 million covered against *hospital expense*, an increase of more than 5½ million over 1951; more than 73 million protected against *surgical expense*, an increase of more than 7½ million; nearly 36 million carried *medical expense* coverage, an increase of 8 million; more than 38 million protected by *disability insurance*, a new high. In addition, nearly 700,000 persons had *catastrophic coverage*—the newest form of voluntary health protection designed to help meet the catastrophic costs of very serious illness.

Additional copies of the report are available on request from the Council on Medical Service.

'53 "Apparatus Accepted" Now Available

Scheduled for release late in October is the 1953 edition of "Apparatus Accepted," a publication of the AMA's Council on Physical Medicine and Rehabilitation. This booklet lists and describes various devices which meet the Council's standards of acceptance. Also included are the Council's rules for submitting products and the minimum requirements set up for certain devices. Copies may be secured on request from the Council.

AMA Prepares New Heart Exhibit

Depicting graphically the pumping action of the heart and its valves, a new health education display has been created by the AMA's Bureau of Exhibits for showings at fairs, expositions, and similar public gatherings.

In this heart exhibit, the sequence of events set in motion by exercise are demonstrated to show the circulation of the blood from the body to the heart, thence through the lungs returning to the heart, and back through the body again. Suggestions to prevent heart strain and symptoms of heart disease are also presented.

This large-scale exhibit requires an extended space 20 feet long and 4 to 6 feet deep. If space is limited, the exhibit may be shown in a booth 10 feet square. State and county medical societies may book the exhibit through the Bureau.

Fall Series of "March of Medicine"

A better look at the nation's leading health problems is in store for the American TV-viewer when the popular "March of Medicine" television series is resumed this fall over the NBC network. Actual live demonstrations from leading medical centers will be telecast to create greater public awareness of the extensive research being carried on by the medical profession. Sponsored by Smith, Kline & French Laboratories and the American Medical Association, the series features one telecast a month —in October, November, and December—over 70 NBC network stations in the United States and also in Ottawa, Toronto, and Montreal.

A report on the extent of research being carried on in various parts of the country on cancer—the nation's second major health problem—will be aired at 10:00 p.m., EST, Thursday, November 5, replacing the U. S. Tobacco Company's "Martin Kane, Private Eye." Highlights of the AMA's annual clinical session in St. Louis will be covered in the third program on December 3.

The first telecast, on October 8, featured a progress report on research and treatment of some types of heart disease—the nation's number one health problem.

Laurels for AMA Staffer

An Honor Award was presented to Dr. W. W. Bauer, director of AMA's Bureau of Health Education, for "distinguished contributions to medical literature" by the American Medical Writers' Association at its 10th annual convention held in Rockford, Ill. The citation reads, in part: "In public health, in writing, in administration, in health education, and in other activities you have provided leadership and wisdom that have been appreciated by many and respected by all. Public health has become for you Health of the Public. . ."

AMA Rule Book on Cosmetics Now Ready

Just off the presses is the revised edition of the "Official Rules of the Committee on Cosmetics of the AMA." This booklet contains requirements for presentation of products and rules governing the acceptance of products by the Committee. Copies are now available on request.

The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Healthy Growth

Highly encouraging is the report of the Health Insurance Council on its annual survey of accident and health coverage in the United States.

Every phase of protection against the unexpected costs of hospital, surgical and medical care was increased to new record high levels during 1952, and every section of the country participated in the gains. . .

The Health Insurance Council noted that 1952 was also marked by increasing acceptance of . . . coverage . . . to meet what it termed the "catastrophic cost" of very serious illness.

The rapid growth of the various forms of health insurance through voluntary, co-operative effort is in keeping with the American way of life and provides a strong answer to those who think that it is a problem which should be tossed into the lap of government.—WAUSAU DAILY RECORD-HERALD, Sept. 24, 1953.

Excellent Medical Facilities

Any sick person requiring fast, emergency treatment can get it at a few moments' notice anywhere in Wisconsin. This availability of competent medical care was disclosed at the State Medical Society meeting in Milwaukee this week.

Virtually every inhabited part of the state is less than 25 miles from a hospital. Excellent ambulance services are available, particularly in rural sections where they are needed most. . .

The doctors urged the public to know beforehand what to do in case sudden illness strikes the family. To the individual who has not had the foresight to arrange for medical service before an emergency, the following facilities are available in every community:

A medical society-operated call service, a privately-operated physicians' exchange, a hospital through which a physician can be contacted, or police assistance in obtaining the services of a physician.

The Medical Society also urges the family to get acquainted with a physician whose services are available whenever needed. It is especially important to know where this doctor is when anyone in the family becomes ill suddenly and dangerously.—SHEBOYGAN PRESS, Oct. 7, 1953.

Political Convention

To people who have asked why the Capital Times paid so much attention to the argument over the Bricker amendment at the convention of the House of Delegates of the State Medical Society of Wisconsin, we have replied with this question:

Judging from the way the medical profession has thrown itself into politics in recent years, isn't it proper to cover a medical convention as if it were just another political convention?—MADISON CAPITAL TIMES, Oct. 8, 1953.

Shortage Emphasized Again

Dr. Kane, psychiatrist for Brown county, has been receiving a salary of $8,240 a year. Recently she informed the Brown county board that Marquette county, Michigan, had offered her an additional $5,200 a year if she would devote her services for one day a week to those needing attention in that Michigan community. Dr. Kane requested the Brown county board to either permit her a day off each week to go to Marquette or to increase her salary to $11,000 a year.

In that situation, the Brown county board quite naturally decided to investigate the matter . . . It learned that few counties in Wisconsin provide a psychiatrist for the reason that they cannot locate qualified persons to accept the task. . .

We have mentioned the actual case of Dr. Kane . . . because of sharp criticism of the Eisenhower administration in dropping about 100,000 college graduates engaged in certain research work that was considered today relatively unimportant. . .

Only five years ago, the then president of Harvard, Mr. Conant, warned that he had become concerned because we were educating so many people in so many professions we might learn "that our economy could not support." . . .

Most entrants at college are optimistic and willing. Had they been presented with an honest picture of the overloading of students in social classes and the necessity for far more graduates in every phase of medicine, thousands of them would have seen the light and gone the right way, helping the country, helping themselves, relieving the national payroll of an unnecessary burden, and relieving themselves of frustration and discouragement.—WAUKESHA FREEMAN, Oct. 5, 1953.

Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

CONSTIPATION IN PREGNANCY:

Satisfactorily controlled with Metamucil®

Metamucil, with its physiologic principles of "smoothage" and "normohydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill[1] suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet, during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

SEARLE Research in the Service of Medicine

Society Proceedings

Kenosha

Dr. F. A. Kordecki, medical director of Willowbrook Sanatorium, spoke on "Recent Trends in Management and the Changing Status of Tuberculosis and Other Pulmonary Diseases" at the September 3 dinner meeting of the Kenosha County Medical Society. Held at the sanatorium, the meeting opened with a welcoming speech by Mrs. Rosella Nugent, superintendent, who emphasized the importance of maintaining the "patient-family doctor relationship" even though the patient must remain at the sanatorium for many months. "The family physician is invited to Willowbrook to see his patient and examine the x-rays and medical records any time he wishes," she said.

Guests at the meeting were *Dr. A. A. Pleyte*, medical director of the Wisconsin Anti-Tuberculosis Association; *Dr. E. E. Bertolaet*, Kenosha health director; and nurses and other members of the city health department.

Outagamie

Members of the Outagamie County Medical Society gathered at the Riverview Country Club in Appleton on the evening of September 16 to pay tribute to a colleague who has spent 50 years in the practice of medicine—*Dr. E. L. Bolton* of Appleton. A native of Tomah, Doctor Bolton first set up practice in Chilton in June of 1903, on his graduation from Marquette University School of Medicine. In 1920 he moved to Appleton and in 1923 formed an association with *Dr. E. F. Mielke*, with whom he now operates the Bolton–Mielke Clinic.

Winnebago

Speaker at the October 1 dinner meeting of the Winnebago County Medical Society, held at the Hotel Athearn in Oshkosh, was *Dr. Sture A. M. Johnson* of Madison, dermatologist at Wisconsin General Hospital. Doctor Johnson discussed "Common Dermatoses."

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

A week-end meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology was held at Leathem Smith Lodge in Sturgeon Bay on September 12 and 13. Speakers for the scientific portion of the meeting included *Dr. Meyer S. Fox* of Milwaukee, who spoke on "The Otologist's Role in the Industrial Noise Problem"; Dr. O. E. Van Alyea, Chicago, who discussed "Recent Advances in the Management of Sinus Disease"; and *Dr. F. Jefferson Davis* of Madison, who addressed the group on "Plastic Surgery of the Lids."

News Items and Personals

Dr. H. M. Levin Takes Associates

Drs. William C. Woods and John E. Martin, both natives of Milwaukee and graduates of Marquette University School of Medicine, have joined *Dr. Harlan M. Levin* at the Lakeland Clinic in Delavan. Both the young physicians interned at St. Joseph's Hospital in Milwaukee and took further training at St. Mary's Hospital there. During World War II Doctor Woods spent 43 months as medical administrative officer in the medical corps, and Doctor Martin served in the European and Japanese theaters of war with the infantry.

On October 1 Doctor Levin began a three-year fellowship in dermatology at Northwestern University Medical School, an assignment that will keep him in Chicago five days a week. He plans to return to his Delavan office on the week ends.

Doctor Macht Addresses Rotarians

Dr. Arthur Macht, staff psychiatrist with the Marshfield Clinic, spoke before the Marshfield Rotary Club at its luncheon meeting on September 14. Introduced by *Dr. Karl H. Doege*, program chairman, Doctor Macht discussed the objectives and methods of psychiatry.

Doctor Brady Honored by ICS

At the annual meeting of the International College of Surgeons, held in New York City during the week of September 14, *Dr. Charles J. Brady* of Lake Geneva was elected to associate membership in the organization. Doctor Brady, a graduate of the University of Wisconsin Medical School, has practiced in Lake Geneva for the past 17 years.

RADON SEEDS

FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

THE RADIUM EMANATION CORPORATION
GRAYBAR BLDG. Telephone MU 3-8636 NEW YORK, N. Y.

SHOREWOOD
HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting October 12, October 26, November 9

Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26

Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 9

Gallbladder Surgery, Ten Hours, starting October 26

General Surgery, Two Weeks, starting October 12

Surgery of Colon & Rectum, One Week, starting October 26

Thoracic Surgery, One Week, starting October 12

Esophageal Surgery, One Week, starting October 19

Breast & Thyroid Surgery, One Week, starting October 26

Fractures & Traumatic Surgery, Two Weeks, starting October 26

GYNECOLOGY—Intensive Course, Two Weeks, starting October 19

Vaginal Approach to Pelvic Surgery, One Week, starting November 2

OBSTETRICS—Intensive Course, Twn Weeks, starting November 2

MEDICINE—Electrocardiograhy & Heart Disease, Two Weeks, starting October 12

Gastroenterology, Two Weeks, starting October 26

Gastroscopy, Two Weeks, starting November 2

DIAGNOSTIC X-RAY—Clinical Course every week by appointment

CYSTOSCOPY—Ten day practical course starting every two weeks

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Your Visit to Milwaukee

Is Made More Enjoyable by Stopping at the SCHROEDER

Metropolitan atmosphere

Cocktail Lounge

Coffee Shop with popular prices

•

The Beautiful EMPIRE Dining Room

Music and Dancing—At Lunch, Dinner, After Theatre

Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER

MILWAUKEE

WALTER SCHROEDER, President

H. H. Christofferson Resigns from State Board of Medical Examiners

H. H. CHRISTOFFERSON

After 16 years on the State Board of Medical Examiners, serving both as member and as president, *Dr. H. H. Christofferson* of Colby resigned from his position after a special meeting of the Board in April. In a letter to the State Medical Society, the Secretary of the Board, *Dr. A. G. Koehler* of Oshkosh, enclosed the following resolution, prepared by the members of the Board "to express in some measure the sentiments of the Board upon learning of his resignation."

WHEREAS, Dr. H. H. Christofferson served as a member of this Board from 1937 to 1953, during which time he also served for many years as president, a fact which in itself is evidence of the esteem in which he was held; and

WHEREAS, the stand which he assumed on the many questions confronting this Board was always firm but, at the same time, fair and just; and

WHEREAS, it was through his untiring efforts that a joint committee was created from the Council on Medical Education and Hospitals of the American Medical Association, and the Executive Council of the Association of American Medical Colleges for the purpose of evaluating foreign medical schools; and

WHEREAS, the new members of this group know of his service as a Board member only by reputation, and are more familiar with the general activities in which he has engaged resulting in benefits to the people of the entire State by improving the standards of the medical profession; and

WHEREAS, we realize that his resignation left a vacancy which has been difficult to fill, now therefore be it

RESOLVED, that this Board cause to be spread on its official records this expression of gratitude and appreciation for his faithful, unselfish, and devoted service, with the hope that the leadership which he has exhibited will serve as an inspiration to the doctors of medicine throughout the State of Wisconsin for many years to come.

AND BE IT FURTHER RESOLVED, that copies of this Resolution be forwarded to:

Honorable Walter G. Kohler, Governor of the State of Wisconsin

J. W. Griffith, M.D., President of the State Medical Society of Wisconsin

C. H. Crownhart, Secretary of the State Medical Society of Wisconsin
Edward J. McCormick, M.D., President of the American Medical Association
George F. Lull, M.D., Secretary of the American Medical Association
K. F. Manz, M.D., President of the Clark County Medical Society
J. W. Koch, M.D., Secretary of the Clark County Medical Society

J. K. Theisen Joins Marshfield Clinic

On the completion of four years of training in surgery at St. Luke's Hospital in Cleveland, Dr. James K. Theisen has joined the surgical staff of Marshfield Clinic and St. Joseph's Hospital. A native of Fond du Lac, Doctor Theisen received his B. S. and M. D. degrees from the University of Wisconsin. After interning at St. Luke's, he spent 18 months in the army as a member of the surgical staff at the Veterans Administration Hospital in Wood and then returned to Cleveland for further training in pathology and surgery.

Arena Honors Dr. E. N. Brown

Dr. Edwin N. Brown, Arena's only physician for nearly 49 years, was honored by his many friends and patients from the little rural community at a celebration on October 10. Held in the Arena High School, the party for Doctor Brown included a social hour, short speeches of tribute to the doctor, and a talk by *Dr. Arnold S. Jackson* of Madison, who showed pictures of his recent tour of Europe.

A 1902 graduate of Northwestern University Medical School, Doctor Brown came to Arena in 1905 after interning at Chicago hospitals and practicing for eight months in Hillsboro. Though he originally planned to stay in Arena for only a year, he somehow never managed to leave and even now, at 77, has no intention of retiring from practice.

THIRD AND TWELFTH DISTRICTS NEWS

T. G. Allin Addresses K of C

Rheumatic fever was the topic of a talk by *Dr. Thomas G. Allin* of Plain at a breakfast meeting of the Knights of Columbus in Spring Green, August 30. Doctor Allin told the group that rheumatic fever is a major cause of death in children from 10 to 14 and is probably dreaded by the medical profession more than polio is.

Doctor Schindler Addresses Educators

Featured speaker at the annual convocation of Waukesha County teachers on September 11 in Waukesha was *Dr. John A. Schindler*, member of the Monroe Clinic. Doctor Schindler chose for his title "Your Disposition Will Ruin You."

BARR X-RAY CO.

Exclusive Wisconsin Distributors for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin

DOERFLINGER ARTIFICIAL LIMB CO.

Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2-2525
MILWAUKEE, WISCONSIN

17-Ketosteroid Determinations

Quantitative Gonadotrophin Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

E. H. Betlach Takes Post at Mercy Hospital

E. H. BETLACH, M.D.

Dr. Eugene H. Betlach of Madison has taken a position in Janesville as radiologist at Mercy Hospital. A graduate of the University of Wisconsin Medical School, where he also took postgraduate training in radiology, Doctor Betlach has been an instructor in radiology at University Hospitals and attending radiologist at the Veterans Administration Hospital in Madison. His work at Mercy Hospital began on October 1.

Doctor Prouty Joins Quisling Clinic

Dr. Lawrence Prouty, former chief resident physician at Bellevue Hospital in New York City, has joined the staff of the Quisling Clinic in Madison. Doctor Prouty specializes in heart ailments.

A graduate of Cornell University Medical College, Doctor Prouty served his internship at Bellevue Hospital and taught at both Bellevue and Cornell. During his stay at the hospital, he developed a new test for vitamin C deficiency.

Doctor Prouty is a member of the Dane County Medical Society, the State Medical Society, the American Medical Association, the American Heart Association, the Harvey Society, and the American Association for the Advancement of Science.

Madison Neuropsychiatric Associates Open Offices

Six Madison doctors and a psychologist have combined forces to become the Madison Neuropsychiatric Associates, with offices in the Tenney Building, Madison. The staff of the new association includes *Drs. Edward R. Hodgson, William C. Lewis, Harold N. Lubing, Max M. Smith,* and *Annette C. Washburne,* neurology and psychiatry; Thelma E. Hruza, Ph. D., clinical psychology; and *Dr. Henry M. Suckle,* consultant in neurological surgery.

UW Gives Heart Disease Course

A three-day course on the diagnosis and treatment of heart disease for practicing physicians was held at the University of Wisconsin Medical School October 20, 21, and 22. The course was conducted by *Dr. Herman H. Shapiro,* associate professor of clinical medicine, with the assistance of 14 members of the medical school faculty.

During the three days physicians received instruction in the reading of electrocardiograms and orthodiagrams and in cardiologic diagnosis. Afternoon lectures stressed recent advances in therapy.

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

SENILE

For further information—
Director, Summit Hospital
Oconomowoc, Wisconsin

Announcing THE SEVENTEENTH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Municipal Auditorium—March 8–11, 1954

GUEST SPEAKERS

Perry P. Volpitto, M. D., Augusta, Ga. ANESTHESIOLOGY
Earl D. Osborne, M. D., Buffalo, N. Y. DERMATOLOGY
Julian M. Ruffin, M. D., Durham, N. C. GASTROENTEROLOGY
Allan C. Barnes, M. D., Cleveland, Ohio GYNECOLOGY
Walter C. Alvarez, M. D., Chicago, Ill. MEDICINE
William D. Stroud, M. D., Philadelphia, Pa. MEDICINE
Lawrence C. Kolb, M. D., Rochester, Minn. NEUROPSYCHIATRY
Nicholson J. Eastman, M. D., Baltimore, Md. OBSTETRICS
A. D. Ruedemann, M. D., Detroit, Mich. OPHTHALMOLOGY
Oscar L. Miller, M. D., Charlotte, N. C. ORTHOPEDIC SURGERY
Francis L. Lederer, M. D., Chicago, Ill. OTOLARYNGOLOGY
Emmerich von Haam, M. D., Columbus, Ohio PATHOLOGY
Philip M. Stimson, M. D., New York, N. Y. PEDIATRICS
Ira H. Lockwood, M. D., Kansas City, Mo. RADIOLOGY
Brian Blades, M. D., Washington, D. C. SURGERY
Samuel F. Marshall, M. D., Boston, Mass. SURGERY
Orvar Swenson, M. D., Boston, Mass. SURGERY
Charles D. Creevy, M. D., Minneapolis, Minn. UROLOGY

Lectures, symposia, clinicopathologic conferences, round-table luncheons, three-dimensional surgical motion pictures, medical motion pictures and technical exhibits.
(All-inclusive registration fee—$20.00)

THE POSTCLINICAL TOUR TO HAWAII BY PLANE AND SHIP—MARCH 14–APRIL 6

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Ave., New Orleans 12, La.

Dr. John W. Harris Honored

J. W. HARRIS, M.D.

Former residents of the Department of Obstetrics and Gynecology at Wisconsin General Hospital met on September 4 and 5 to honor *Dr. John W. Harris* on the occasion on his 25th year at the University of Wisconsin. Doctor Harris is professor and chairman of the Department of Obstetrics and Gynecology at the University Medical School and Wisconsin General Hospital.

In honor of Doctor Harris, the John Warton Harris Obstetrical Society was organized at this meeting. Membership in the society is to be limited to residents trained by Doctor Harris and the members of his department. *Dr. Madeline Thornton*, Madison, was elected president of the society, with Dr. E. Russell Muntz, Ada, Oklahoma, president-elect. *Dr. Alice D. Watts*, Milwaukee, will serve as the society's secretary-treasurer.

Papers presented as a part of the scientific program were "Lesions of the Vulva," by Dr. John Parks; "Abruptio Placentae," by Dr. Howard Tatum, Madison; and "Treatment of Iron Deficiency in Anemia in Pregnancy," by Dr. Curtis J. Lund, New Orleans, Louisiana. An operative clinic conducted by *Dr. Ralph E. Campbell* of the University Hospital, roundtable discussions, and case study presentations completed the scientific program.

Residents and their wives were breakfast guests at the home of Doctor and Mrs. Harris on September 5. Added features of that day's program included a tour of the hospital conducted by Doctor Harris and a dinner at the Madison Club. Among the guests at the dinner were Doctor and Mrs. Campbell and *Dr. Harold M. Coon*, Superintendent of Wisconsin General Hospital, and Mrs. Coon.

L. V. Sprague Heads St. Mary's Staff

Dr. Lindley V. Sprague was re-elected president of the staff of St. Mary's Hospital in Madison at a meeting on September 22. Other members returned to office were *Dr. R. F. Collins*, vice-president; *Dr. T. V. Geppert*, secretary–treasurer; and *Dr. R. S. Gearhart*, delegate to the board of trustees of the Dane County Medical Society.

Doctor Middleton Is Medical Adviser

Dr. William S. Middleton of Madison is one of five civilian physicians and a dentist who have been appointed by Dr. Melvin A. Casberg, new assistant secretary of the Department of Defense, to advise him on military medical policy. Doctor Middleton is dean of the University of Wisconsin Medical School.

Area Physicians Attend ICS Congress

Several physicians from the Third District attended the 18th Annual Congress of the United States and Canadian sections of the International College of Surgeons in New York City from September 13 to 17.

Dr. B. H. Brunkow of the Monroe Clinic staff presented a paper before the College on "The Subcostal Incision as an Approach to the Kidney Pedicle." Other physicians taking part in the discussions were two members of the Jackson Clinic in Madison, *Dr. George H. Ewell* and *Dr. Arnold S. Jackson*, president-elect of the United States section of the College.

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.

Tel. Daly 3021 **Milwaukee, Wis.**

Degrees were granted by the College to two Madison physicians, *Drs. H. Lewis Greene* and *Luther E. Holmgren*. Doctor Greene was unable to accept the award in person.

Rock

The first fall meeting of the Rock County Medical Society was held on September 22 at the Monterey Hotel in Janesville. The after-dinner speaker was *Dr. Charles W. Crumpton* of Madison, who discussed "Heart Disease in Children."

Doctor Shaiken Addresses Convention

At the convention of the National Gastroenterological Association in Los Angeles from October 12 to 14, *Dr. Joseph Shaiken* of Milwaukee presented a paper on "The Patient with Diarrhea." Doctor Shaiken, a 1930 graduate of the Marquette University School of Medicine, is a specialist in diseases of the stomach and intestine.

Chest Physicians Meet

The Wisconsin Chapter of the American College of Chest Physicians held its annual meeting at the Hotel Schroeder in Milwaukee on October 4. *Dr. Joseph M. Lubitz*, assistant professor of pathology at Marquette, was one of the speakers at the afternoon scientific program, which included lectures, exhibits, and motion pictures.

Medication Alone Does Not Solve **THE ALCOHOLIC PROBLEM**

AT IVANHOE—

a specially trained staff deals with the psychiatric, psychological and social aspects of the psychosomatic illnesses resulting in Alcohol Addiction.

Latest therapies and "know-how" have reduced the treatment period to an average of five days. Moderate fees.

Phone or write for information or reservation.

Alcohol patients only.

Restful Homelike Atmosphere
Near the Shores of Lake Michigan

IVANHOE SANITARIUM

of MILWAUKEE, WIS.

A REGISTERED HOSPITAL OF A.M.A.
Member American & Wisconsin Hosp. Assns.

2203 E. IVANHOE PLACE
Phone MArquette 8–4030

Accepted by the Medical Societies
Dedicated to the Medical Profession

Doctors Rice, Morgan Speak on Rheumatic Fever

Drs. Raymond L. Rice and *Sherburne F. Morgan* discussed the problem of rheumatic fever before a group of parents and teachers at Appleton Vocational School on September 24. The meeting was sponsored by the Fox River Valley District Heart Committee in cooperation with the Outagamie County Medical Society.

Doctor Rice is an internist and assistant professor of clinical medicine at Marquette, Doctor Morgan a pediatrician and chief of the cardiac clinic at Milwaukee Children's Hospital.

F. F. Rosenbaum Discusses Heart Therapy

Dr. Francis F. Rosenbaum, Milwaukee cardiologist, was one of the members of the faculty for a course in "Recent Advances in Cardiac Therapy" held in Charleston, W. Va., on September 16. Doctor Rosenbaum, a past president of the Wisconsin Heart Association, is on the medical faculty at Marquette and is associated with Columbia Hospital and Milwaukee Children's Hospital.

Doctor Shutkin Presents Paper

"The Medical Treatment of Peptic Ulcer with a New Anticholinergic Compound" was the title of a paper presented by *Dr. Michael W. Shutkin* of Milwaukee at the National Gastroenterological Association Convention in Los Angeles on October 14.

Doctor Shutkin is an assistant clinical professor of medicine at Marquette University and attending gastroenterologist and gastroscopist at Milwaukee County Hospital, Mt. Sinai Hospital, and St. Luke's Hospital in Milwaukee.

Milwaukee Academy of Medicine

Guest speaker at the 894th meeting of the Milwaukee Academy of Medicine, held at the University Club of Milwaukee on October 20, was Dr. Richard B. Capps of Northwestern University Medical School, who delivered the Florence Hobert Memorial Lecture on "Viral Hepatitis with Particular Reference to Epidemiology." A dinner and a special business meeting preceded Doctor Capps' talk.

SOCIETY RECORDS

New Members

R. G. Evenson, 914 North Central Avenue, Marshfield.

J. L. McClung, 2020 University Avenue, Madison.

J. T. Duncan, Jr., 625 57th Street, Kenosha.

Changes in Address

C. E. Hopkins, Camp Lejeune, North Carolina, to 2320 Eton Ridge, Madison.

E. W. Henry, Camarillo, California, to 527 North Lucerne Boulevard, Los Angeles, California.

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
604 N. Water St.
R. G. Bidwell
Phone: BR 2–1016

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

"Insufficient Funds"

IT is bad enough to have those words stamped across a check when one is hale and hearty and working.

But when that happens to a widow with small children or an old man who is through working—well, you tell us what could be much worse.

A Wisconsin Life Insurance policy can be one of your surest and easiest ways to eliminate both of the above situations.

WISCONSIN LIFE INSURANCE CO.
30 W. MIFFLIN ST. MADISON, WIS.

J. M. Sinnett,* Jacksonville, Florida, to U.S.N.R., C.A.G. 17, Fleet Post Office, New York, New York.

R. F. Schoen,* Beaver Dam, to 01934421, 7505th AFES, Fort Buchanan P.R., A.P.O. 851–A, New York, New York.

H. E. Breckenridge, Blackwood, New Jersey, to Odd Fellows Home, 822 Gregnon Street, Green Bay.

J. W. Pavelsek, Cambria, to Henney Clinic, Portage.

J. J. Tordoff, West Allis, to Munn–Koch Clinic, Janesville.

J. R. Couch, San Antonio, Texas, to 9329 West Wisconsin Avenue, Milwaukee.

J. B. Miale, Marshfield, to Jackson Memorial Hospital, Miami, Florida.

Herbert Frank, Green Bay, to 1505 Eleventh St., S., Fargo, North Dakota.

E. M. Parkin, La Crosse, to 16 South Henry Street, Madison.

N. P. Anderson, La Crosse, to % J. E. Achorn, Box 1163, Crystal River, Florida.

L. S. Kellogg,* San Antonio, Texas, to 633 Oak Street, Oregon.

A. E. Kuehn, Viroqua, to 133 Claremount Avenue, San Antonio, Texas.

H. R. Duffy,* San Francisco, California, to First Marine Air Wing, M.C.A.S., El Toro, California.

K. C. Mickle, Milwaukee, to 704 South Van Buren, Green Bay.

P. J. Bartzen, Holly Ridge, North Carolina, to 105 West Silver Spring Road, Milwaukee.

A. M. Kohn,* Stewart Air Force Base, Tennessee, to 4888 North 21st Street, Milwaukee.

H. T. Schroeder, Milwaukee, to 601 Isabelle Avenue, Racine.

S. H. Ferguson,* New Lisbon, to 0–1934568, Box 28, Wm. Beaumont Army Hospital, El Paso, Texas.

J. N. Moore, Madison, to 2926½ Roosevelt Drive, Youngstown, Ohio.

M. J. Talbert, Madison, to 4½ South Third Street, Grand Forks, North Dakota.

E. H. Betlach, Madison, to 2115 Woodruff Boulevard, Janesville.

H. S. Ashe,* Pensacola, Florida, to M.C.A.S., % Infirmary, Cherry Point, North Carolina.

J. J. Frederick,* Cudahy, to AO–2260900, 3700 Medical Group, Lackland A.F.B., San Antonio, Texas.

L. P. Wolf,* Fort Belvoir, Virginia, to Camp Tokyo, Medical Section, A.P.O. 613, % Postmaster, San Francisco, California.

Morris Mitz,* Falmouth, Massachusetts, to 1206 West Mitchell Street, Milwaukee.

J. K. Olinger,* Fort Lawton, Washington, to 2212 West State Street, Milwaukee.

Harry Vander Kamp, Baraboo, to 213 Montrose Avenue, Kalamazoo, Michigan.

J. C. Pinney, Sturgeon Bay to % H. P. Secher, 2901 18th Street, N.W., Park Crescent Apartment 415, Washington, D. C.

*Military Service.

C. O. Lindberg, Grantsburg, to Sandstone, Minnesota.

W. B. Hobbins,* Madison, to 1233 North Hancock, Colorado Springs, Colorado.

H. S. Caskey,* Sumter, North Carolina, to AO-1907119, 66th Medical Group, A.P.O. 130, % Postmaster, New York, New York.

R. L. Hartzell,* San Antonio, Texas, to 3319 Mountain View Drive, Boise, Idaho.

DEATHS

P. R. MINAHAN, M.D.

Dr. P. R. Minahan, oldest practicing physician in Brown County, died on July 20. Born near Chilton on June 7, 1875, he was 78 at the time of his death. Survivors include his wife and a son, Rodger P., of Westminster, California.

Past - president of both the State Medical Society and the Brown - Kewaunee - Door Counties Medical Society, Doctor Minahan held a distinguished place in Wisconsin medicine. The *Journal* is pleased to reprint excerpts from a tribute to Doctor Minahan prepared for the Brown County Historical Society by *Dr. O. A. Stiennon* of Green Bay, a personal friend of the late doctor.

"The sudden death on July 20 of Dr. P. R. Minahan was a grievous blow and an irreparable loss not only to his local community but to a host of friends and fellow practitioners who had come to know and admire him during his long service in the interest of organized medicine in Wisconsin.

"It was my good fortune to have been counted among his friends and to have known him intimately throughout his long medical career of 55 years. After graduating with honors in 1898 from what is now the University of Illinois College of Medicine, Doctor Minahan launched his medical practice in Casco, Kewaunee County.

". . . In 1907 he was obliged to quit his practice because of ill health, and resided in Prentice for two years to recuperate fully. He resumed his practice in Algoma until 1912, when he was called to Fond du Lac to replace his cousin, Dr. W. E. Minahan, who had met a tragic death in the 'Titanic' disaster. During World War I he served as a Captain in the Army Medical Corps, stationed at Fort Riley, Texas. In 1921 he moved to Green Bay, where he practiced until his death.

"P. R., as he was affectionately called by his friends, . . . combined the qualities of the old

family physician with the science and skill of the present. With advancing years he remained young in spirit, retaining a keen interest in new scientific and organizational development and enjoying the association of the younger members of the profession who instinctively came to him with their problems and never failed to receive a word of wise counsel and advice.

"His was a mind of many facets; he was a philosopher who viewed life in broad perspective. He appreciated only sound human values and had no patience with sham, pretense, and insincerity. The two salient qualities of his character were humility and gentleness. His sympathies were ever with the poor and underprivileged.

". . . Were we to write his epitaph it would be a simple one. His life was a shining example of gentle devotion to the cause of the sick. He walked humbly through life doing good unto others and died loved and honored by all who knew him. More than this surely no man can achieve."—O. A. STIENNON, M.D.

Dr. Albert C. Hammett, Crivitz physician, died on September 10 after an illness of several months. Born in Chicago on October 25, 1871, he was 81 at the time of his death.

Doctor Hammett was an 1896 graduate of the University of Michigan Medical School at Ann Arbor. He practiced close to 40 years in Chicago and while there was on the staff of the Ravenswood Hospital, serving as chief of staff from 1929 to 1934. In 1937 he moved to Crivitz, where he practiced until shortly before his death.

Doctor Hammett was a medical officer in the British Army in Southern Rhodesia during the Boer War and also served in the U. S. Army during World War I.

Doctor Hammett's wife died three years ago. He is survived by four sons.

Dr. Donald Waters, 82, died on September 15 after an illness of two months. He was born on March 25, 1871.

A native of Middlesex County, Province of Ontario, Canada, Doctor Waters came to this country in 1893 and spent three years working in the office of two physicians in Port Huron, Michigan. The preliminary training in medicine he received under their guidance prompted him to enroll in the Detroit College of Medicine (now Wayne University College of Medicine) in 1896. On his graduation in 1900 he practiced briefly in a Michigan town and then moved to Wisconsin Rapids, where he remained to practice until his death.

Doctor Waters played a prominent role in the establishment of Riverview Hospital and served for a number of years as a member of the hospital's board of directors. A member of the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, Doctor Waters received the pin of the Fifty Year Club

Wide Medical Interest in New Knox Gelatine "Eat and Reduce" Plan

Developed and supervised by competent clinical authority, the new Knox "Eat and Reduce" Plan is intended especially for your overweight patients in otherwise normal health.

The plan has been tested on overweight patients with fine results. In addition, many physicians (and their families) have written us about their gratifying personal results with this plan.

The Knox "Eat and Reduce" Plan is a simple, sensible regimen that places no burden of exercise or hunger on the patient. Quite the contrary, it permits three tempting, solid meals daily, plus between-meal feedings. The menus have been carefully selected so as to provide an abundance of vitamins, minerals and protein. Many of the dishes utilize Knox Gelatine, which is, of course, all protein and no sugar — thus being an effective aid in weight reduction.

AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES.

Knox Gelatine U.S.P.
ALL PROTEIN NO SUGAR

USE THIS COUPON! ***Write today!***
Knox Gelatine, Johnstown, New York Dept. WS

Please send me FREE copies of the "Eat and Reduce" Plan, and Diets.

Name..... M.D.

Address.....

City..... Zone..... State.....

of the State Medical Society in 1950 and was granted life membership in the Society in 1951.

Doctor Water's wife died early this year. He is survived by three sons, William, Albuquerque; John, New York City; and Hugh Robert, St. Louis, Missouri.

Dr. Frederick A. Kretlow, Milwaukee physician and surgeon for 28 years, died on September 20 at the age of 54.

Born in Milwaukee in 1898, Doctor Kretlow graduated from the former Marquette Academy and from Marquette University School of Medicine in 1923. Since 1925 a member of the staff of Misericordia Hospital, he was elected chief of staff on January 1 of this year.

Doctor Kretlow was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Survivors include the doctor's wife, Josephine; a son, Frederick, Jr.; and a daughter, Frances Ann, all of Whitefish Bay.

Dr. Robert J. Goggins, general practitioner in Oconto County for 54 years, died on September 23 at the age of 76. He was born on a farm near Chilton on October 29, 1876.

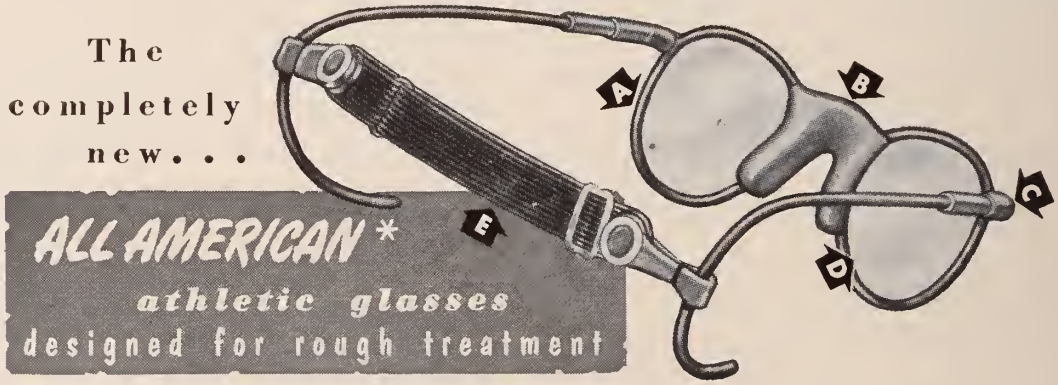
Doctor Goggins graduated from the University of Illinois College of Medicine in May 1899 and set up practice a month later in Suring, Oconto County. In March 1900 he moved to Oconto Falls, where he practiced continuously ever since except for a period of military service during World War I.

A member of county, state, and national medical societies, Doctor Goggins was a past president of the Oconto County Medical Society and was granted life membership in the State Medical Society in 1951. He once served as health officer of Oconto Falls.

He is survived by his wife and three daughters.

RADIUM and RADIUM D+E
(Including Radium Applicators)
FOR ALL MEDICAL PURPOSES
Est. 1919
Quincy X-Ray and Radium Laboratories
(Owned and Directed by a Physician–Radiologist)
HAROLD SWANBERG, B. S., M. D., Director
W. C. U. Building Quincy, Illinois

The completely new . . .



A. EXTRA STURDY ALL-METAL FRAME
B. "CUSHION FIT" SHOCK ABSORBENT RUBBER NOSE PIECE
C. ENDS COVERED TO PROTECT OTHER PLAYERS
D. SAFETY PRESCRIPTION LENSES WITH HIGH BASE CURVE
E. EXPANSIBLE, ADJUSTABLE "GLASS GARD"* HEADBAND

- One Price for All Prescriptions up to and Including 7 Diopters—Case Included
- Order Complete Sample Available at Nominal Cost or Write for Further Information

*Pat. Pend.

Since 1913 Benson OPTICAL COMPANY

EXECUTIVE OFFICES • MINNEAPOLIS, MINNESOTA

Complete Laboratories Serving Wisconsin: Beloit, Eau Claire, La Crosse, Stevens Point, Superior, Wausau, and Duluth, Minn.

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

New Physicians' Manual

The physicians' manual which has just been distributed to members of the State Medical Society is designed to help them and their office assistants with matters concerning Wisconsin Physicians Service. They will find it useful:

1. in billing procedures;
2. in the understanding of Blue Shield contracts and benefits;
3. in explaining certain technicalities of Blue Shield contracts and provisions to patients, if the occasion arises.

It should be a great advantage to the doctor if he sees to it that his office help uses this manual consistently, and becomes thoroughly familiar with it.

The manual includes, on pages 5 through 9, a detailed description of benefits provided under Blue Shield contracts. A separate page is devoted to each of the five major items of coverage—surgical, medical, anesthesia, x-ray, and maternity benefits.

Page 10 indicates, in clear, unmistakable language, what benefits are definitely *not* provided, such as services performed for diagnostic purposes, medicines, drugs, appliances, blood, operations for beautifying purposes, and the like.

On page 4 will be found a list of definitions of terms which are used in Blue Shield contracts, the exact meaning of which is not always fully understood by the subscriber.

Waiting periods, or the time which must elapse between the time an individual subscribes to Blue Shield and the time he can receive certain benefits, are explained on pages 12 and 13.

The full payment provisions of Blue Shield are described on pages 14 and 15. These pages indicate what income a person carrying a certain schedule of benefits must have in order to be eligible for "full payment." Persons with incomes over a certain figure may be charged by participating physicians a sum in addition to that provided under the Blue Shield fee schedule.

A detailed schedule of Blue Shield benefits occupies pages 17 through 33, and starts with a convenient index. Where several procedures are necessary for the same patient, a multiple procedure formula applies. This may be found on page 34.

Billing procedures cause trouble to the office help of some physicians, so this matter is explained in detail. Pages 36 and 37 give directions for billing hospitalized cases, and pages 38 and 39 for non-hospitalized cases.

Whenever you need additional PSR's for home and office surgery, write to Blue Shield, Box 1109, Madison. They will be sent immediately upon request.

A number of pages are left blank for the notes and questions of the physician and his assistant. If you have questions or suggestions to make concerning Blue Shield and its procedures, please send them to the Blue Shield office.

A limited supply of additional copies of the manual is available so that a new copy may be secured if one is lost or accidentally destroyed.

For convenience in using the manual, an index has been printed on the front cover. This index refers to the general topic, and more details may be found by referring to the page indicated. For example, the cover index refers the reader to page 17 for the "Schedule of Benefits." On page 17 there is a detailed alphabetical index to all items covered by the schedule of benefits. This should prove convenient to all who need to refer to the manual for identification of procedures in reporting on the Physicians Service Report.

For information or advice

Write • 704 E. GORHAM ST., MADISON, WIS. *Phone* • 6-3101 MADISON, WIS.

DISTRIBUTION OF GAMMA GLOBULIN FOR MEASLES AND INFECTIOUS HEPATITIS PROPHYLAXIS

A Message from the Wisconsin State Board of Health Bureau of Communicable Disease Control

Gamma globulin for the prophylaxis of measles and infectious hepatitis is now being distributed through the same agencies as gamma globulin for poliomyelitis prophylaxis.

These agencies are the eight district offices of the State Board of Health located in Madison, Elkhorn, Fond du Lac, Sparta, Wisconsin Rapids, Green Bay, Chippewa Falls, and Rhinelander. The seven city health departments acting as distributing agencies are Madison, Janesville, Kenosha, Milwaukee, Racine, West Allis, and Sheboygan. Gamma globulin is also available to physicians from the Bureau of Communicable Disease Control, State Office Building, Madison.

The gamma globulin for both measles and infectious hepatitis prophylaxis can be distributed for use only in household contacts. A household contact is defined as an individual living in the same home as the patient for a period of not less than 24 hours during the period of contagiousness of the disease.

The following criteria for distribution have also been established:

1. The gamma globulin is to be used only for prophylaxis of measles and infectious hepatitis. It cannot be distributed as a therapeutic agent.
2. Gamma globulin for measles prophylaxis will be distributed for use in each susceptible household contact *under* three years of age. It will also be distributed for use in susceptible household contacts over three years of age when the physical condition of the contact is such that the physician feels prophylaxis is advisable.

   The quantity which will be distributed for each eligible household contact will be 2 cc. except in the case of susceptible pregnant females, in which instance 10 cc. will be distributed.
3. Gamma globulin for the prophylaxis of infectious hepatitis will be distributed to physicians for all susceptible household contacts regardless of age.

   The quantity which will be distributed for prophylaxis of this disease in each eligible household contact will be based on a recommended dosage of 0.01 cc. per pound of body weight, with a maximum of 2 cc. for any single individual.

Physicians may secure gamma globulin from the nearest and most convenient distributing source. It will be unnecessary to submit request forms, and it is recommended that requests be made in person or by phone.

The following information, however, will be necessary at the time the request is made:

1. Name, age, and address of the patient.
2. Diagnosis and date of onset of illness.
3. In the case of measles:
   a) The number of susceptible household contacts under three years of age.
   b) The name of the susceptible household contact over three years of age, and the nature of his illness.
   c) The name and period of gestation of susceptible pregnant household contacts.
4. In the case of infectious hepatitis:
   a) The number of susceptible household contacts, regardless of age, and their approximate weights.

CAPT. LEWIS L. MILLETT
USA

T/SGT. R. S. KENNEMORE
USMC

LT. COL. R. R. MYERS
USMC

LT. THOMAS HUDNER, JR.
USN

PFC. H. A. CAFFERATA, JR.
USMCR

M/SGT. HAROLD E. WILSON
USMCR

In all, 104 men have won the Medal of Honor in Korea. The men here stand as representatives of them—and of all the service men and women to whose devotion we in America owe our security this Christmas of 1953.

Peace...

their Christmas Wish for us!

THESE are some of the bravest men on earth. Yet these young holders of the Medal of Honor were never fighters for the love of fighting. They are men of war with a dream of peace.

They want a world in which small wide eyes can gaze in rapture at a tinselled tree. Where a happy Christmas is a child's inalienable right—because fear and force have at last given way to peace and law and goodwill. They have fought ably for peace, with courage "above and beyond the call of duty." Can we, at home, do something for it, too?

Yes. Beginning now, each of us who earns can put some part of his earnings into United States Defense Bonds. For by these Bonds we make our own families secure, first of all. Then, out of the security of our families, we build the strength of America—to *stay* at peace in a world where peace still is only for the strong.

You can invest in Defense Bonds *best* through the Payroll Savings Plan where you work or the Bond-A-Month Plan where you bank. Won't you begin—today?

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Fundamentals of Psychiatry. By Edward A. Strecker, M. D., Sc.D., LL.D., Litt.D., F.A.C.P.; Professor of Psychiatry and Chairman of the Department, Undergraduate and Graduate Schools of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania, Philadelphia, and Germantown Hospitals; Consultant and Chief-of-Service, Institute of the Pennsylvania Hospital; Consultant to the Surgeons General, U. S. Army and U. S. Navy; Senior Consultant in Psychiatry, Veterans Administration; Consultant in Mental Hygiene. U.S.P.H.S.; Chairman, Committee on Psychiatry, National Research Council; Chairman, Committee on Psychiatry, American National Red Cross. Fifth Edition. Philadelphia, J. B. Lippincott Company, 1952. Price $4.50.

As the title suggests, this book, now in its fifth edition, is directed toward providing some basic knowledge and understanding of psychiatry. This most recent edition has been modified from the previous ones primarily by revision of the chapter on "Psychosomatic Medicine and Psychiatry," by more extensive discussion of nomenclature, and by the addition of a new chapter on "Treatment Including Psychotherapy." Generally speaking, it will probably be of some value to the psychiatrically unsophisticated; it is not, to this reviewer's mind, adequate for use as a text for medical students.

While the author pays much lip service to the holistic approach to human maladaptation, the book is replete with vestiges of the descriptive era of psychiatry and a predominant "organic" approach to etiology. An example of the former is the heavy and almost exclusive emphasis upon clinical symptomatology as a basis for classification; an example of the latter is his frank statement that "psychopathic personality" is a "defect and not a pathologic reaction." Such positions are more characteristic of psychiatry in the 1920's than of contemporary knowledge. Moreover, there are some statements which do the reader a disservice; for example, the author repeats Freud's pre-1900 views on the etiology of anxiety and neurasthenia as though Freud himself had not later revised them and as though contemporary dynamic knowledge did not refute them.

The chapter on the psychoneuroses is grossly inadequate, even descriptively. Similarly, the chapter on treatment will hardly provide the practitioner in other areas of medicine with useful psychotherapeutic tools, for it is largely a rehash of procedures probably already used by the practitioner and largely ineffectively. In view of the author's statements regarding the complexity of emotional decompensations, one would think these attitudes would be reflected in the discussion of treatment. He implies, by omission, that psychoneurotic reactions will rather easily succumb to the efforts of the general practitioner with the use of simple blandishments. A healthier emphasis would have been a careful delineation of the areas in which the novice psychotherapist might reasonably expect some success and a further careful delineation of those syndromes requiring the specialist's care.

While the foregoing reservations (and some others) will appear of considerable importance to the psychiatrist, the book can be recommended with caution to practitioners in other areas of medicine if the latter will keep in mind that its orientation and its brevity and its oversimplification necessitate further reading.—R. R.

Cardiac Therapy. By Harold J. Steward, M. D., associate professor of medicine, Cornell University Medical College, New York; attending physician, New York Hospital; head of division of cardiology, Department of Medicine, New York Hospital-Cornell Medical Center. New York, Paul B. Hoeber, Inc., 1952. Price $10.00.

This is a highly comprehensive textbook of nearly 600 pages written by a cardiologist who has had rich experience and has devoted many years to the handling of cardiac patients. Etiology, physiology, and pathology are presented in connection with many of the cardiac conditions discussed, but throughout the book the chief emphasis is on treatment. No aspect of cardiac therapy has been omitted

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D. — John E. Leach, M. D.
J. Frampton Wyman, M. D. — Lloyd F. Jenk, M. D.
Hubert H. Blanchard, M. D. — James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

ACCIDENT • HOSPITAL • SICKNESS INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS

	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building — Omaha 2, Nebraska

$200,000.00 deposited with State of Nebraska for protection of our members

Prescribe Journal-advertised products and you prescribe the best.

and the material is presented in a clear and practical manner. Recently introduced drugs such as ACTH and Pronestyl are included but with proper reservations. As stated by the author in the preface, "The book has been written dogmatically, since throughout I have wished to reflect my own methods of treatment. When there are opposing points of view, however, I have described them and given the reason for the plan which I have preferred." This policy has to be kept in mind constantly by the reader, as it appears to the reviewer that the author has been slow to accept some of the newer methods of treatment which have been widely tested and generally accepted.

The first chapter in the book appropriately deals with congestive heart failure, the therapy of which is discussed in detail, but the reviewer cannot agree with some of the basic ideas expressed by the author. A full chapter of 58 pages is devoted to digitalis and its administration. Other drugs such as diuretics and anticoagulants are likewise handled in a comprehensive manner. The treatment of cardiac irregularities is dealt with at considerable length, but in this department the reviewer feels there is also room for improvement. The chapter on rheumatic fever and rheumatic heart disease is particularly well done. Paragraphs sprinkled through the book on "What To Tell the Patient" give many practical and helpful hints.

The author has taken cognizance of the growing importance of diet in the various forms of heart disease and hypertension. The last chapter in the book has been devoted to this subject, the material is well presented, and a number of excellent diets are included.

This book is recommended not for the medical student or for the physician who himself has had only limited experience in the handling of cardiac patients, but more as a reference work for the internist or the cardiologist who has had sufficient experience of his own to utilize the many excellent suggestions which it contains and at the same time modify or reject certain of the therapeutic recommendations as his own judgment may dictate.—C.M.K.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., Clinical Professor of Neurology, Columbia University, New York; Consulting Neurologist, The Mount Sinai Hospital, Montefiore Hospital, and Rockland State Hospital, New York. Seventh edition. Philadelphia, W. B. Saunders Company, 1952.

Medical students and physicians alike will find well-organized neurologic orientation and good factual information in the *Textbook of Clinical Neurology* by Israel Wechsler. The seventh edition, 1952, incorporates present-day accurate knowledge of neurologic diseases and syndromes. This well-written and up-to-date textbook outlines necessary technics for comprehensive neurologic examinations and for psychologic evaluation tests and discussions. It gives basic information about psychoneurotic reactions

For over 70 years...

One Wing of the Lodge

Specialists in the Treatment of Alcoholic Addiction

Treatment of the "problem drinker" is more than a sobering-up process; it is a rehabilitative procedure which must be tailored to the needs of the individual.

Years of intensive research and specialized clinical experience enable us to follow through in all phases of modern restorative treatment—gradual withdrawal, physical rehabilitation, re-orientation and re-education.

You may refer female as well as male patients—we are also equipped to care for narcotic or barbiturate addiction. Moderate rates; treatment period sometimes shortened to just two weeks.

Registered by the American Medical Assn.
Member of the American Hospital Assn.

We invite your inquiry

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

WISCONSIN DOCTORS

Note These Reliable Wisconsin Firms Which Sell Dependable Products, Services

BERGMANN PRESCRIPTION CENTER
102 King Street, Phone: 7–2267
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

CENTRAL DRUG
An unusually large stock of Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: 3–4736

MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
1505 Tower Avenue Superior, Wisconsin

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

MAYER DRUG
Harry F. Mayer, Proprietor
A Complete Prescription Department
Biologicals and Ampoules
Kenosha, Wisconsin

To Keep Abreast of Medical Literature
To Aid in Preparing Medical Talks, Papers
USE THE
MEDICAL LIBRARY SERVICE
Service Memorial Institutes Building
MADISON

ALWAYS ASK FOR
Borden's
MILK and ICE CREAM
PHONE 5-4551
KENNEDY MANSFIELD DIVISION

COSMETIC *HAY FEVER?*

Prescribe UNSCENTED AR-EX Cosmetics

When perfumes or scented cosmetics cause allergic reactions — prescribe UNSCENTED AR-EX COSMETICS. Clinically tested to meet your high standards. Smart, fashion-right for patient acceptance. All needed beauty aids. Send for free Formulary

UNSCENTED

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

AR-EX
HYPO-ALLERGENIC
Cosmetics

Clinically tested on allergic patients for use by allergic patients

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
(The Pioneer Post-Graduate Medical Institution in America, Organized 1881)

OBSTETRICS AND GYNECOLOGY

A full time course. In Obstetrics: Lectures, prenatal clinics, witnessing normal and operative deliveries; operative obstetrics (manikin). Gynecology: Lectures; touch clinics; witnessing operations; examination of patients, pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

SURGERY AND ALLIED SUBJECTS

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

and describes in a precise manner the clinical symptoms and signs of neurologic diseases. The brief history of neurology is unique and most instructive, covering the field well. Throughout the text one sees and hears the experienced neurology teacher who orients and guides the reader from his vast clinical workshop and from his practical and specialized experience. The textbook is highly recommended to the medical profession since it is an instructive, clear, and very helpful orientation text in the science and clinical application of neurology.

David Wechsler is an authority in the field of psychologic examination; two of the best general intelligence scales (the Wechsler–Bellevue and the Wechsler Intelligence Scale for Children) and the standard clinical test for memory (the Wechsler Memory Scale) are the results of his research. His work on the rise and decline of general intelligence with age has caused a major reorganization of thinking about the concept of I. Q. I think that Wechsler oversells the use of diagnostic tests to detect brain disease, and claims accuracy and consistency for them which only the most skillful clinician could achieve. His "deterioration index" (part of the Wechsler–Bellevue Scales) is still the subject of controversy. His discussion of testing instruments is brief but good.—H.H.R.

Symposium on Treatment of Trauma in the Armed Forces. Sponsored jointly by the Division of Medical Sciences of the National Research Council and the Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D. C., Army Medical Service Graduate School, 1952.

This symposium is divided into six sections. In each an effort is made to present the most recent information available about specific aspects of the various subjects. The six sections are entitled (1) Organization for Handling of Trauma in Military Campaigns and Civil Disasters, (2) The Emergency Treatment of the Wounded Man, (3) Surgical Problems Related to Traumatic Injury, (4) A Round Table on the Rehabilitation of Battle Casualties, (5) Complications Related to Traumatic Injury, and (6) Research in Military Medicine. Included in the book are numerous illustrations and tables and also some bibliographies.

Following each paper there is an interesting discussion of the subject with questions from the floor. For instance, under the discussion of "Experimental Wound Ballistics" by Dr. Frederick W. Light, Jr., questions were raised about the use of body armor in the field and whether the medical corps was prepared to recommend to the line a standard issue of body armor for the infantry. Doctor Light states that it has been shown conclusively that ground troops of all types—riflemen, heavy weapon groups, men on the quad 50's, and men on the mortars—can wear this armor without any undue limitation of mobility and with considerable psychologic advantage. He further states that this armor is being tested and that the results of these trials will have to be made available before any recommendation can be made to standardize this item of equipment. Questions concerning the weight of the armor, the number of casualties among men wearing it, and the possible use of a lighter type of helmet were all answered during this discussion.

This book should be of utmost interest to those dealing with trauma, particularly those in the armed forces who may have difficulty in obtaining periodicals in which these subjects have been previously discussed. This symposium represents the present-day thinking in regard to trauma of both civilian and service personnel.—K.E.L.

Professional Films

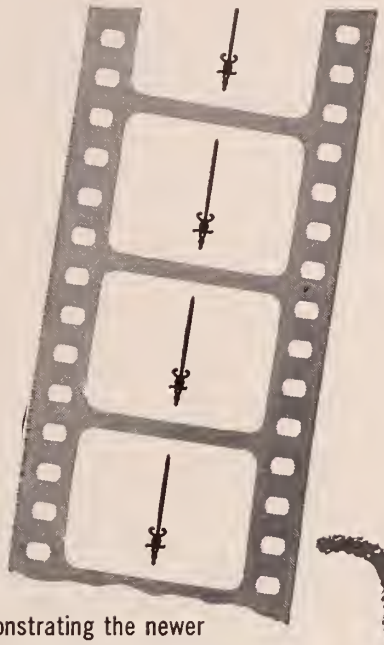
for

Hospital Staff Conferences

Medical Schools

Postgraduate Refresher Courses

State and County
Medical Society Meetings



A distinguished series of color films graphically demonstrating the newer diagnostic techniques in cancer. Sponsored jointly by the American Cancer Society and the National Cancer Institute of the United States Public Health Service.

Cancer — The Problem of Early Diagnosis

Breast Cancer — The Problem of Early Diagnosis

Gastrointestinal Cancer — The Problem of Early Diagnosis

Uterine Cancer — The Problem of Early Diagnosis

Oral Cancer — The Problem of Early Diagnosis

Lung Cancer — The Problem of Early Diagnosis (In production for winter release)

All are 16 mm. sound films in color

As a service to the medical profession, showings of these and other teaching films in our Professional Film Loan Library will be arranged by the Division of the American Cancer Society in your state upon request.

American Cancer Society, Inc.
WISCONSIN DIVISION
652 East Gorham St.
Madison 3, Wisconsin

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

FOR SALE: 30 ma Continental x-ray and vertical fluoroscope, used, shock proof. Accessories include tank, hand timer, and cassette holder. Address replies to Box 517 in care of the Journal.

FOR SALE: Office equipment and instruments of a recently deceased Wisconsin physician. Address replies to Box 518 in care of the Journal.

FOR SALE, by widow of physician, examination table, office desk, and an assortment of instruments. Address replies to Box 519 in care of the Journal.

OPHTHALMOLOGY LOCATION WANTED: UW graduate, returning to Wisconsin for family and business reasons, wishes association with board member ophthalmologist. Training includes 3-year residency in EENT and basic science course in eye followed by several years of EENT practice. Could give excellent office and surgical assistance. Arrangements of association open. Address replies to Box 508 in care of the Journal.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately. Write Box 505 in care of the Journal.

FOR SALE: Spencer microscope in carrier. Also other physician's instruments. Address replies to Mrs. J. J. Fitzgerald, Eagle, Wis.

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WANTED: General practitioner to join two-man group in thriving midwestern Wisconsin college community. Salary guaranteed first year, then partnership; new modern hospital facilities available. Address replies to Box 510 in care of the Journal.

OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

WANTED: Young, progressive clinic in western Wisconsin needs pediatrician, certified or board qualified, and a general practitioner. Excellent opportunity. Address replies to Box 521 in care of the Journal.

AVAILABLE AT ONCE: Established general practice in small town in west central Wisconsin, heart of the fishing and hunting country. Owner has gone overseas with Army. Ample income from surrounding territory. Small hospital within 12 miles. Completely equipped suite of offices in part of large, newly decorated home with spacious grounds overlooking small lake. Reasonably priced for quick sale. Excellent opportunity for young physician. Address replies to Mrs. G. Mitchell, Merrillan, Wis.

FOR SALE: Practice and fully equipped 15-room office in central Wisconsin college town of 6,000. Gross over $40,000. New open hospital in city. Excellent for 3-man group. Because of health, owner will remain on part-time basis only. Address replies to Box 522 in care of the Journal.

FOR RENT OR SALE: Doctor's home, and office space in downtown office building. Also equipment. Good location for general or EENT practice in small city in year-round resort area with good hunting and fishing. Newly opened hospital in city. Address replies to Box 528 in care of the Journal.

WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

FOR SALE: Office building of late Dr. C. F. Peterson in Independence. Tile veneered, 21 by 46 ft., full basement, oil furnace. Beauty parlor upstairs could be converted into apartment. A few instruments for sale. Records go with instruments. Adddess replies to Box 524 in care of the Journal.

FOR SALE: Mobile 30 ma shockproof x-ray unit. Jones basal metabolism unit in excellent condition. Direct-writing electrocardiograph. Microscopes, new and used. Assorted cassettes with intensifying screens. Surplus x-ray filter grids, never used. FCC-approved short-wave diathermy units. Slightly used film filing cabinet. Write C. C. Remington, 1204 W. Walnut Street, Milwaukee.

INSTITUTIONAL position wanted by woman physician. Well trained in psychiatry, including shock treatments. Wisconsin license. Address replies to Box 525 in care of the Journal.

FOR RENT: Large one-room office suitable for consultant, particularly a psychiatrist, on one-day-a-week basis or full-time if desired. Active community in south central Wisconsin, with drawing population of 50,000. Office in professional building, has private bathroom and walk-in storage closet. Reasonable rental. Address replies to Box 526 in care of the Journal.

FOR SALE: General practice in Madison and complete office equipment. Owner retiring, will stay to introduce new physician. Address replies to Box 527 in care of the Journal.

FOR SALE: McCaskey Register System for physicians. Desk model, four drawers. Steel cabinet, 30½ by 17 by 32 inches. Price, $50.00. Address replies to H. G. E. Mallow, M. D., 210 Madison Ave., Fort Atkinson, Wis.

EXCELLENT OFFICE SPACE AVAILABLE for specialist in ENT, internal medicine, or radiology. Largest downtown building in Racine. Reasonable rental. Write or call Alex Wald, 610 W. Wisconsin Ave., Milwaukee, Wis.

FOR SALE to one purchaser: Entire office equipment of deceased general practitioner. Surgical equipment, furniture for 2 offices, 3 filing cabinets, instrument cabinet, new reception room furniture, 2 examining tables, 2 air conditioners, x-ray equipment, darkroom equipment, 2 scales. Address replies to Mrs. Paul Currer, 9405 Ridge Blvd., Wauwatosa 10, Wis. Tel. SPring 4–2686.

FOR SALE: X-ray machine built especially for head work. Darkroom equipment. Stainless steel operating table. 20 years' records of large EENT practice. Now stored in Wisconsin Rapids. Practice unopposed. Any reasonable offer accepted. Write to E. G. Barnet, M. D., 1011 Professional Bldg., Phoenix, Ariz.

CERTIFIED ELECTROCARDIOGRAPHER desires to interpret electrocardiograms by mail. Replies by return mail on day of receipt. $1.50 per interpretation. Address inquiries to Box 529 in care of the Journal.

PHYSICIANS, with or without public health training, and pediatricians needed in Maternal and Child Health program. Salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Write Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wisconsin.

FOR SALE: General practice in rural community of 2,000 people in southwestern Wisconsin. Estimated net income of $10,000 for first year. Will sell for value of inventory of office supplies and equipment. Housing facilities available in community. Address replies to Box 530 in care of the Journal.

Upjohn

long-acting androgen:

Depo-Testosterone

Trademark Reg. U. S. Pat. Off.

CYCLOPENTYLPROPIONATE

Each cc. contains:

Testosterone Cyclopentylpropionate .....50 mg. or 100 mg.

Chlorobutanol ..... 5 mg.

Cottonseed Oil .....q.s.

50 mg. per cc. available in 10 cc. vials

100 mg. per cc. available in 1 cc. and 10 cc. vials

The Upjohn Company, Kalamazoo, Michigan

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- M. A. Hardgrove, Milwaukee
Delegate ---------- R. N. Allin, Madison
Alternate ---------- R. A. Frisch, Milwaukee

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- Harry Tabachnick, Milwaukee
Alternate ---------- E. Madison Paine, Green Bay
Secretary-Treasurer- J. T. Petersik, Winnebago

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmelster, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer- Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Chairman ---------- John W. Doolittle, Madison
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ J. B. Miale, Marshfield
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- D. M. Angevine, Chairman, Madison
Etheldred L. Schafer, Madison
W. H. Jaeschke, Madison
Delegate ---------- W. A. D. Anderson, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- E. H. Pawsat, Fond du Lac
Vice-Chairman ----- S. E. Kohn, Milwaukee
Secretary ---------- J. R. Schroder, Janesville
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	10, 11
American Meat Institute	18
Ames Company, Inc.	8
Ar-Ex Cosmetics	42
Audiphone Utilities	31
Ayerst, McKenna & Harrison, Ltd.	13
Baker Laboratories	19
Barr X-Ray Company	27
Bayer Company	12
Benson Optical Company	34
Bergmann Prescription Center	41
Camel Cigarettes	16
Central Drug	41
Chicago Medical Society	4
Cook County Graduate School of Medicine	26
Doerflinger Artificial Limb Co.	27
Eaton Laboratories, Inc.	6, 7
Endocrine Laboratories	27
Hotel Schroeder	26
House of Bidwell	31
Hurley X-Ray Company	5
Ivanhoe Sanitarium	30
Keeley Institute	40
Kennedy–Mansfield	41
Knox Gelatine	33
Lederle Laboratories	facing page 18
Lilly, Eli and Company	22
Mallard, Incorporated	21
Mallatt Pharmacy	41
Mather Pharmacy	41
Mayer Drug	41
Mead Johnson and Company	49
Medical Protective Company	5
Merck and Company	15
Milwaukee Sanitarium	50
New Orleans Graduate Medical Assembly	29
New York Polyclinic	42
Orthopedic Appliance Company	30
Parke, Davis and Company	2, 3
Pfizer, Charles and Company, Inc.	17
Physicians & Hospitals Supply Co., Inc.	14
Physicians Casualty Association	39
Professional Business Service	607
Quincy X-Ray & Radium Labs.	34
Radium Emanation Corporation	25
Rennebohm's	41
Rogers Memorial Sanitarium	50
Sacred Heart Sanitarium	39
St. Croixdale Sanitarium	5
Searle, G. D. and Company	23
Shorewood Hospital Sanitarium	25
Summit Hospital	28
Time Insurance Company	605
Upjohn Company	45
Winthrop-Stearns, Inc.	20
Wisconsin Life Insurance Company	31
Wyeth, Inc.	9

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

H. KENT TENNEY, Madison, President
A. J. McCAREY, Green Bay, President-Elect
L. O. SIMENSTAD, Osceola, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1956
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
R. E. Garrison__Wisconsin Rapids
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1956
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1954
J. C. Griffith_____Milwaukee
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1955

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
G. E. Forkin, Menasha, 1955

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holsteln	J. M. Guthrie Brillion	
Chippewa	B. F. Rahn Cornell	C. A. Kemper 119½ Bridge Chippewa Falls	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	S. L. Chase 905 University Ave. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bayley Beaver Dam	R. F. Boock 119½ Front Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	W. H. Schuler Ripon	H. J. McLane 80 Sheboygan St. Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	N. E. Bear Monroe	D. E. Mings Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

* Except June, July, and August.
** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	John E. Thompson Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	F. E. Zantow Oconto	G. R. Sandgren Suring	
Oneida–Vilas	M. J. Donohue Antigo	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	Milton Davis Milton	H. M. Snodgrass 500 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Fourth Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	G. J. Kelm Muskego	J. A. Bartos 717 N. East Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.

THE WISCONSIN MEDICAL JOURNAL

Copyright by the State Medical Society of Wisconsin, 1953

Volume 52 DECEMBER 1953 Number 12

Newer Developments in Radiation Therapy of Cancer

By TRAIAN LEUCUTIA, M. D.
Detroit, Mich.

FOR nearly half a century the radiation therapy of cancer has been carried out mainly with two agents, roentgen rays and the gamma rays of radium, both of which are electromagnetic vibrations able to penetrate cancer tissues to great depths, thus producing their destruction.

As was to be expected, the evolution of the various methods used in treating with roentgen rays was from the beginning intricately interwoven with the constant development of increasingly powerful energizing apparatus, enabling the production of more and more penetrating roentgen rays. First there was the rather empirical superficial roentgen therapy with voltages of 80 to 100 kv., which was used for the treatment of lesions on the surface or near the surface of the body, much in the same manner as one would irradiate with ultraviolet light. Then, with the advent of the Coolidge tube in 1920, deep roentgen therapy with voltages of 200 kv. followed. This permitted adequate treatment of most of the deep-seated cancers and gave such an impetus to the scientific clinical application of irradiation that today, more than 30 years later, it still constitutes the most generally preferred method. In the early thirties some investigators[1,2] started to use supervoltage roentgen therapy with energies of 500 kv. to 2 mev. However, because of the enormous size of the apparatus used and the great expense involved in installing and operating it, the progress here was considerably slower. Only after World War II, following the incorporation of radical improvements of design in the newer apparatus, did this form of therapy find a somewhat wider acceptance. Finally during the last decade, betatron[3] or megavoltage roentgen therapy[4] with 20 to 25 mev. has been tried in a few places.

At Harper Hospital in Detroit, through fortunate circumstances, supervoltage roentgen therapy has been used routinely since 1932 for the treatment of malignant neoplasms.[5] Based on experience with more than 6,500 cases treated and a perusal of the literature,[6,7] it was established that this method has the following three advantages over deep roentgen therapy: (a) it permits the administration of a certain physical dose to cancer with less effect on the skin, (b) it allows a simplification of the technic of irradiation by reducing the number of portals necessary for the purpose of cross firing, and (c) because of the greater depth dose and the lesser attenuation of the beam, it makes possible a more homogeneous irradiation, especially in large volumes of tissue.

Commensurate with this improvement in the physical aspect of irradiation there was an improvement in the immediate response as well as in the long-range statistical results in certain groups of cancer.[5-7]

The other radiation agent commonly employed for the treatment of cancer is radium or, more rarely, some other member of the three naturally radioactive families. The physical and clinical foundations of the various technics, such as surface, intracavitary, and interstitial applications of this form of radiation therapy, are well understood and the indications for their use precisely established.

In the early days there was a tendency to use radium also as a source of gamma-ray beam therapy by housing it in a shielded container of special design provided with a mechanism which would permit treatment of the cancer at a certain distance from the source in a manner similar to that employed in roentgen therapy. The first units usually contained 1 to 5 Gm. of the element and, in view of the low intensity of the gamma-ray beam emitted, irradiation had to be carried out at close range, the distance between the radium source and the patient rarely exceed-

ing 10 cm. Later the quantity of the radium was increased to 10 Gm. At present there are 2 units in operation, each containing 50 Gm. of radium. The price of such units is, of course, considerable and, apart from other considerations, this factor alone has contributed greatly to the restriction of the wider use of this form of therapy.

Recently, the growing availability of artifically produced radioisotopes with energetic gamma-ray emission has rapidly changed this situation. By making use of high-flux reactors it is now possible to obtain suitable radioactive sources which enable irradiation of the cancer with large gamma-ray outputs at the distances commonly used in roentgen therapy.[8]

It has been the custom for many years to use the term *radium teletherapy* to distinguish that form of treatment in which the radium is not placed in contact with the lesion (either externally, intracavitarily, or interstitially) but at a certain distance away from it, however short this distance might be. With the increasing use of larger radioactive sources, a redefinition of this term may prove necessary. It is suggested that treatment at a distance of less than 15 cm., usually requiring small sources, be called *plesiotherapy* to express the fact that the irradiation is carried out "near" the source, and that the name *teletherapy* be reserved for treatment at distances of 50 cm. or more with larger sources. It is possible that an intermediary unit may also be built, permitting adequate treatment under certain conditions at 30 cm., which then may be named *brachytherapy* or *short-distance therapy.*

Brucer[9] and Aebersold,[10] who have contributed enormously to the study of the therapeutic usefulness of the various radioactive materials, express the opinion that there are at least six practical isotopes which are suitable for gamma-ray beam therapy: iridium (Ir^{192}), cobalt (Co^{60}), europium ($Eu^{152-154}$), tantalum (Ta^{182}), cesium (Cs^{137}), and cerium (Ce^{144}). Of these, iridium 192 and cobalt 60 have been successfully used for several years in plesiotherapy. Since 1951, cobalt 60, which undoubtedly is the best source available at the present, has been employed in an increasing number of large teletherapy units. This radioisotope has several attractive properties. It is easily produced in a nuclear reactor by neutron absorption, it can be made into a source of a high specific activity, and it can be conveniently assembled into a treatment unit of small size. It emits two gamma rays of 1.17 and 1.33 mev., so that the beam may be considered as essentially monochromatic, comparing favorably with a roentgen-ray beam produced by a supervoltage apparatus of equivalent energy. Its only disadvantage is its relatively short half-life of 5.3 years, necessitating replacement of the source approximately every 5 to 8 years. The initial output of a 1,000 curie cobalt 60 source is 30 to 35 roentgens per minute at a distance of 80 cm., and the depth dose values are similar to those obtained with a 2.5 mev. roentgen apparatus.

Of the remaining isotopes, cesium 137 promises to be the most desirable source in the future, surpassing even cobalt 60. The greatest advantage of this isotope is its long half-life of 33 years, so that a replacement may not be necessary for as many as 35 to 40 years. In addition, it emits gamma radiation of 0.66 mev. energy, requiring considerably less shielding than is the case with the cobalt 60 unit. Hence a fully assembled cesium 137 teletherapy apparatus will be much more compact and flexible than a cobalt 60 teletherapy apparatus of identical output. There are still some serious difficulties which delay the supplying of large quantities of cesium, and further improvements are necessary in the design and assembly of the treatment head containing the radioactive source, but it is expected that these difficulties will be overcome in the next few years.

It is evident from the foregoing that the introduction of large teletherapy units, utilizing gamma-ray beams of different energy ranges emitted by various radioactive sources, constitutes another milestone in the progress of the treatment of cancer by radiation therapy. As already stated, supervoltage roentgen therapy with 500 kv. to 3 mev. has definite advantages over the conventional deep roentgen therapy with 200 kv. in treating certain groups of malignant neoplasms. For various reasons, however, of which the financial aspect was perhaps the most important, the use of this form of irradiation had to remain restricted to large institutions. Gamma-ray teletherapy now offers the same advantages under more favorable conditions. The biologic action of the

660 kv. energy rays of cesium 137 or of the 1.17 and 1.33 mev. energy rays of cobalt 60 will be identical with the biologic action of comparable energy roentgen rays, but the clinical application of the treatment will be greatly simplified. Whichever energy range may be chosen, the teletherapy apparatus will prove more flexible, versatile, and economical than the corresponding supervoltage roentgen-ray machine. For this reason, and since the complex problems of electrical energization and daily dose calibrations are eliminated, it is probable that this form of radiation therapy will find wide usefulness in the near future.

---

10 Peterboro at Woodward.

REFERENCES

1. Leucutia, T., and Corrigan, K. E.: Present status of roentgen therapy with voltages above 200 kv.; technical development and medical application, Am. J. Roentgenol. 31:628–662 (May) 1934.
2. Trump, J. G., and Cloud, R. W.: Production and characteristics of 3,000 kilovolt roentgen rays, Am J. Roentgenol. 49:531–535 (April) 1943.
3. Kerst, D. W.: Betatron, Radiology 40:115–119 (Feb.) 1943.
4. Leucutia, T.: Megavoltage roentgen therapy (editorial), Am. J. Roentgenol. 49:540–543 (April) 1943.
5. Leucutia, T.: Comparative value of deep and supervoltage roentgen therapy; statistical analysis of 5 year results in selected groups, Am. J. Roentgenol. 58:347–356 (Sept.) 1947.
6. Buschke, F., Cantril S. T., and Parker, H. M.: Supervoltage Roentgen Therapy, Springfield, Ill., Charles C. Thomas Co., 1950.
7. Holmes, G. W., and Schulz, M. D.: Supervoltage radiation; review of cases treated during 8 year period (1937–1944 inclusive), Am. J. Roentgenol. 55:533–554 (May) 1946.
8. Leucutia, T.: Teletherapy with various radioactive sources (editorial), Am. J. Roentgenol 69:108–111 (Jan.) 1953.
9. Brucer, M.: New developments in teletherapy, Nucleonics 10:40–46 (April) 1952.
10. Aebersold, P. C.: Radioisotopes as sources of gamma rays for therapy, Am. J. Roentgenol. 70:126–135 (July) 1953.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize of $300, and third prize of $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than ten years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held at the Waldorf–Astoria, New York City, May 31–June 3, 1954.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954.

W. M. A. TO MEET IN ROME NEXT YEAR

The World Medical Association will hold its 1954 meeting in Rome, September 26 to October 2. Since 1954 is a Holy Year, there will be heavy demands for transportation and hotel reservations. Any A.M.A. member who wishes to attend this meeting should write to the World Medical Association, 345 East 46th Street, New York 17, as soon as possible. The W.M.A. will secure transportation and hotel reservations and will help plan any side tours of Europe which the member desires. No charge is made to the physician for this service.

Leukemia and Its Complications*

By MAURICE HARDGROVE, M. D.

Milwaukee

LEUKEMIA is a fatal disease, resembling a neoplastic process. More than 5,000 deaths from leukemia occur in the United States each year. There are some reasons to suspect that leukemia is increasing in frequency. It is nine times more common in radiologists than in non-radiologists. It was found ten times more often in the atom bomb-exposed population of Hiroshima than in the non-exposed.

Associated diseases, complications, and errors in management may shorten the natural course of the disease. Care in treatment of the associated disorders, prompt attention to the complications of leukemia, and caution in the use of modern antileukemic agents will prolong life. The chronic leukemias live from three-and-a-half to seven years; the acute leukemias from one to two months to a year or more. Cure is not yet in the picture.

A recent review of 25 patients who died of leukemia at VA Hospital, Wood, Wisconsin, and of another 25 seen in practice has yielded some impressions which are worthy of mention.

Associated Diseases

Associated diseases, unrelated to leukemia, are important to recognize and treat properly. In this series of cases some of the associated diseases and causes of death other than leukemia were as follows: duodenal ulcer, bronchopneumonia, carcinoma of the prostate, abscess due to diverticuli of the colon, lung abscess, decubitus ulcer, cellulitis, lobar pneumonia, fungus infections of the skin and lungs, nephrolithiasis, peritonitis due to perforation of the colon, hepatitis, miliary and pulmonary tuberculosis, thyroiditis, intussusception of the intestine, myocardial infarction, congestive heart failure, cerebral vascular accidents, acute appendicitis, pyelonephritis, diabetes, cancer of various organs, bronchiectasis, septicemia, and pulmonary embolism. It would appear that over one third of the deaths in chronic leukemia are unrelated to the leukemia itself.

Cardiorespiratory, genitourinary, neurologic disorders and cancer were more common in cases of chronic lymphatic leukemia, because of the older age of these patients. Some leukemic patients may have more than two diseases. These diseases are for the most part cardiovascular in origin and occur in the same older age groups. With the advent of sulfonamides and antibiotics, infections may now be cured. Identifying the offending bacteria and testing their sensitivity to the antibacterial agents are of great importance in successful therapy.

Complications of Leukemia

It is important to recognize the complications of leukemia and to treat them in a prompt and proper manner. A myelophthisic normocytic anemia appears in chronic leukemia. It improves when the leukemic process is brought under partial control. However, a hemolytic anemia in chronic lymphatic leukemia does not always respond in the same fashion. Cortisone or ACTH are sometimes of value in the correction of this acquired hemolytic process. Splenectomy has met with variable results of temporary nature but, for the most part, is to be discouraged. Transfusions of red cell mass are used to keep the hemoglobin well over 11 Gm. and the red blood cells above 3,000,000. An unpredictable response to cobaltous chloride may sometimes occur.

Weakness and hypermetabolism frequently go hand in hand and vary in the stages of leukemia. Multiple and nutritious feedings are important. Antithyroid drugs have not been successful in lowering the basal rate, for it is thought to be due to an increase in cellular metabolism. However, one patient was noted to respond to propylthiouracil with an apparent cooling-off period.

Associate Professor of Clinical Medicine, Marquette University School of Medicine; Senior Consultant in Medicine, VA Hospital, Wood.

*Presented at the Therapeutic Conference, Columbia Hospital, Milwaukee, May 1953.

Bronchitis and bronchiectasis are more common in the older patients with chronic lymphatic leukemia. Hilar adenopathy increases the incidence of these bronchial conditions. The antibiotics should be used freely in these situations to prevent as well as to combat the common infections—pneumonitis, abscesses, pyelocystitis, and septicemia, for example. Splenic infarction is more common in chronic myelogenous leukemia, and its occurrence seems unpredictable. Holding the spleen size down by antileukemic therapy may aid in the prevention of splenic infarction. Bleeding in all types seems best controlled by transfusions. Platelet transfusions in thrombocytopenic situations are of interest. Though their use is not completely established, they may be of some temporary help. Local x-irradiation in adenopathy, priapism, and splenomegaly is routine.

Treatment of Leukemia

The use of antibiotics, psychotherapy, and other modern methods for the treatment of all associated diseases and complications will undoubtedly increase the length of life of the person with leukemia.

Regularly spaced, total body radioactive phosphorous (P^{32}) or roentgen irradiation, given in titrated small doses, is a modern method of therapy for chronic leukemia. P^{32} is of greater value in chronic myeloid leukemia than in chronic lymphoid leukemia. Five millicuries are given intravenously and, if necessary, three millicuries are given six weeks later. Two mistakes may be made in roentgen therapy of chronic leukemia. Either the dosage may be excessive, with resultant x-ray sickness, undernutrition, and acute flare-up; or the patient may be allowed to relapse too far without treatment. Pyridoxine hydrochloride, administered in a dosage of 25 mg. three times a day, may be helpful in relieving x-ray sickness. Cysteine has also been thought to be of value.

The number of chemical agents which have shown some activity against neoplastic diseases has increased considerably in the past ten years. None are known to be curative but many are arrestive and palliative. Nitrogen mustard (HN2), colchicine, urethane, arsenic, the diamidines, antimony, and the endocrines are readily available. I should like to stress mainly the toxic effects of some of the newer agents, for one must avoid making the leukemia patient sicker.

Radiomimetic Agents

Patients with mycosis fungoides are often benefited by nitrogen mustards (HN2 or HN3) for periods of one to five months. Eventually, however, the favorable response can no longer be repeated. Occasionally, the nitrogen mustards have been used in chronic lymphatic leukemia. A dosage of 4 to 6 mg. every other day for four days has been given. In Europe, the intravenous administration of 0.6 mg. daily for weeks has been thought to give prolonged remissions. The toxic effects are mainly those of depression of the hematopoietic tissues. If the erythrocytes, leukocytes, and platelets are carefully checked several times a week, one may readminister the drug when the blood elements have returned to an approximately normal level. Antibiotics are used to prevent the infection seen with agranulocytosis. Strenuous antihemorrhagic measures are needed to combat bleeding if it occurs. Nausea and vomiting are more common after the intravenous use of nitrogen mustard than when TEM (triethylene melamine) is used orally. TEM is of less value in chronic myelogenous leukemia. Five milligrams or less a day are used and repeated only after careful consideration. Oral thio-TEPA (Triethylene Thio-Phosphoramide) appears to be less toxic to the bone marrow than TEM. R_{48} (Beta-naphthyldi-2-chloroethylamine) acts like the nitrogen mustards in chronic lymphatic leukemia. It has been used extensively by the British.

Mitotic Inhibitors

The use of urethane (ethyl carbamate) has been fairly well studied in chronic myelogenous leukemia with peripheral leukocytosis. In two to four weeks, there is a drop in the leukocytes, and general clinical improvement appears in many of the patients so treated. A decrease in the spleen size is noted but to a lesser extent than with x-irradiation or P^{32} therapy. Urethane has been of some value in plasma cell leukemia and multiple myeloma. Protracted use of urethane may result in marrow hypoplasia with leukopenia, thrombocytopenia, and anemia. Gastric irritation is not uncommon. Depressed bone marrow elements are elevated

slowly after cessation of the drug. In one patient, cobaltous chloride seemed to be of value in the treatment of a urethrane-induced hypoplastic anemia. A temporary period of high hemoglobin and erythrocytes, which was polycythemoid in nature, was noted.

Colchicine has been of interest in blood cell culture work because of its action as a mitotic inhibitor. It has not been used extensively or too successfully *in vivo*.

Potassium arsenite (Fowler's solution) in doses of 15 to 30 drops a day may be used in chronic myelogenous leukemia. It is cumulative, and is a hematopoietic depressant. Careful hematologic and clinical evaluation is necessary when it is used. Benzene is a leukopenic agent now seldom used in leukemia. Two new and incompletely evaluated antileukemic drugs are 6-Mercaptopurine for acute leukemia and Trisarsine (Mc 2865) for chronic leukemia.

Toxic Cellular Agents

Myleran GT–41 (1, 4-dimethane–sulfonyloxy butane) is a substance toxic to cells of the myeloid type seen in chronic myelogenous leukemia, but the drug needs further investigation. Total hypoplasia of the marrow may follow its use. Urethane and x-ray have been used more frequently in multiple myeloma and plasma cell leukemia than the diamidines (stilbamidine and pentamidine) because of the toxic reaction of the latter when used intravenously. Facial neuropathies have followed the use of the diamidines. They may be a help in blastomycosis complicating a leukemia.

Antimetabolites

Folic acid antagonists, classed as antimetabolites and known as Aminopterin, A-methopterin, and amino-an-fol, are of great interest. The oral dose of Aminopterin is ½ mg. and of A-methopterin, 2 to 5 mg.; the intramuscular dose of amino-an-fol is 30 mg. All three have produced temporary remissions in one third of the children having acute lymphatic leukemia. Folic acid deficiency produced by these drugs may cause the development of macrocytosis, megaloblastosis, and multilobulation of the neutrophils in leukemia. Severe hematopoietic depression of the marrow may occur. Systemic toxic signs, such as intestinal tract ulcerations, diarrhea, hemorrhage, weakness, and anorexia, often appear. Alopecia and skin eruptions may also follow the use of these drugs. Adding folic or folinic acid (citrovorum factor), which overrides the good effects of the antagonists, may be of aid in repairing the toxic reactions. Life has been prolonged from six to nine months in children with acute leukemia by the use of these drugs, combined with transfusions, antibiotics, and cortisone or ACTH. Consistent, though transient, hematopoietic effects are seen with PABA (para-aminobenzoic acid) in chronic myelogenous leukemia more frequently than in chronic lymphatic leukemia.

Endocrine Substance

The estrogens and androgens have not been used to as great advantage in the leukemias as they have in metastatic lesions of prostate and breast carcinoma. However, favorable initial responses are seen in 50 per cent of patients with acute lymphatic leukemia who have been treated with cortisone or ACTH. Repeated responses may occur. Current medical literature and experience is replete with information about proper dosages of these substances and the dangers involved in their use.

Conclusion

Prolonging the life of patients with acute and chronic leukemia is a present-day challenge. Modern therapy applied to the associated diseases and the complications of leukemia has helped to meet this challenge.

Enthusiastic use of the currently available antileukemic agents must be combined with judgment and recognition of their toxic effects.

---

208 East Wisconsin Avenue.

Decompression of the Ganglion and Posterior Root of the Fifth Nerve for Trigeminal Neuralgia

By EDWARD J. KIEFER, M. D., and DAVID CLEVELAND, M. D.
Milwaukee

MANY attempts have been made to improve on the surgical treatment of trigeminal neuralgia. In 1901, Frazier, following the suggestion of Spiller, performed the first successful section of the sensory root of the fifth nerve using the intracranial, transtemporal approach. With minor modifications, this procedure has been the most commonly used surgical method for the relief of trigeminal pain.

Sectioning of the sensory root produces a facial anesthesia which occasionally is rather annoying to the patient. Furthermore, when the first division of the fifth nerve is sectioned, there is the danger of keratitis because of the anesthesia of the cornea. Dandy[1] has suggested that the fifth nerve be approached through the cerebellar route, maintaining that postoperative keratitis did not occur when this procedure was carried out. Later, Sjöqvist[2] described a trigeminal tractotomy in which the descending branch of the fifth nerve was cut in the medulla, thereby eliminating pain but retaining tactile sensation. Neither operation is widely used.

Recently Taarnhöj[3] published a preliminary report describing a decompression operation using the intradural approach. In this procedure, the posterior portion of the sheath of the gasserian ganglion and dura over the nerve root are opened widely without cutting any of the sensory fibers. At the time of his paper he had successfully operated on 10 patients, the longest period of pain relief being eight months. To date, there are no reported recurrences but, as was pointed out, not enough time has elapsed to evaluate this group adequately. The great advantage of this operation is, of course, the absence of anesthesia on the operated side. Love[4] reported a case in which he used a similar technic. He has subsequently performed the operation numerous times with gratifying results.

At the time of this writing eight decompression operations have been performed by the authors. In each instance, the pain was relieved. In a few of the cases, however, a transitory spotty anesthesia resulted on the operated side. All but one case were relieved immediately after surgery. The one patient who did not obtain immediate relief gradually became pain free over a period of seven days. Because of the newness of the procedure, the operation was carefully explained to each of the patients. It was explained that it might be necessary to perform a standard section of the sensory root if the decompression operation should be unsuccessful. Taarnhöj[3] described 3 cases in which the postoperative pain persisted. In one of the cases, the pain persisted for as long as eight days. Baker and Love[5] have had similar experiences and, in at least one instance, the patient was returned to the operating room in a few days and the sensory root was divided in the usual manner. The authors are unable to explain the physiologic or anatomic rationale at present, but because of the satisfactory results to date the continued use of the procedure is indicated. If its use meets the test of time, the procedure should become the operation of choice.

Technic

We have changed the technic described by Taarnhöj to one we consider easier and safer, with less danger of hemorrhage. Through the usual temporal incision a temporal craniotomy is performed. The sheath of the ganglion is opened to the dural fold at the petrous ridge, where the dura under the temporal lobe overlying the ganglion is opened to the dural fold. The dural fold is then clipped and crushed with a hemostat and divided to expose the posterior fossa and posterior root. In only one case was it necessary to apply silver clips to the petrous sinus to assure hemostasis.

In the series of cases discussed, the longest period of pain relief resulting from the decompression operation has been 20 months. The most recent operation was per-

formed two months ago. To date, there have been no recurrences of the trigeminal pain after the decompression operation. At the time of this writing, our observations in dealing with this operation are essentially the same as those of others doing the same procedure.

Summary

1. The treatment of trigeminal neuralgia, including the decompression operation, is discussed briefly.

2. A modification of the decompression operation is described and advocated.

3. Eight cases of trigeminal neuralgia in which the decompression operation was performed by the authors are described. In each case there has been complete relief of pain; the oldest case is one in which 20 months have elapsed without recurrence of pain.

324 East Wisconsin Avenue.

REFERENCES

1. Dandy, W. E.: Treatment of trigeminal neuralgia by cerebellar route, Ann. Surg. 96: 787–795 (Oct.) 1932.
2. Sjöqvist, O.: Eine neue Operationsmethode bei Trigeminusneuralgie: Durchschneidung des Tractus spinalis trigemini, Zentralbl. f. Neurochir. 2: 274–281 (Jan.) 1938.
3. Taarnhöj, P: Decompression of the trigeminal root and the posterior part of the ganglion as treatment in trigeminal neuralgia: preliminary communication, J. Neurosurg. 9:288–290 (May) 1952.
4. Love, J. G.: Decompression of the gasserian ganglion and its posterior root: a new treatment for trigeminal neuralgia (preliminary reports), Proc. Staff Meet., Mayo Clin. 27:257–258 (July 2) 1952.
5. Baker, G. S., and Love, J. G.: Personal communication to the authors.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The 20th Annual Meeting of the American College of Chest Physicians will be held in San Francisco from June 17 through 20, 1954. Physicians interested in presenting scientific papers on any phase in the diagnosis and treatment of heart and lung disease should send a 100-word abstract, not later than Jan. 1, 1954, to Dr. Edgar Mayer, Chairman of the Committee on Scientific Program, 850 Fifth Avenue, New York 21, New York.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1954 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of $1,000, and the essay will appear on the program of the 1954 meeting of the society. Essays submitted in this competition must be received not later than March 1, 1954. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, Secretary, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

Treatment of Thyrotoxicosis with Radioactive Iodine*

By E. C. ALBRIGHT, M. D.
Madison

THE purpose of this report is to present a summary of experience in the Department of Medicine of the University of Wisconsin Medical School and the University Hospitals in the radioiodine treatment of thyrotoxicosis during the period between May 1947 and September 1952. During this interval 327 patients have been observed and treated.

Evaluation of Patients for I^{131} Treatment

Obtaining successful results with any new therapeutic agent depends closely upon careful evaluation of patients accepted for such therapy. In evaluating patients for radioiodine therapy a detailed history is essential, with particular attention to nervousness, emotional instability, appetite, weight loss, cardiac consciousness, loss of strength, inincreased sweating and heat intolerance, tremor, ocular symptoms, and the development of goiter. Next in importance is the complete physical examination, with emphasis directed to eye signs, the size and consistency of the thyroid, pulse, pulse pressure, and neuromuscular and cutaneous changes. In the laboratory, a hemogram, urinalysis, chest x-ray, and cholesterol determination are obtained for general information although they are of little diagnostic significance here.

The final step in evaluation of patients for radioiodine therapy is the diagnostic test of thyroid function with radioiodine. Many variations of this test are available, but we have selected as the most practical one the 24-hour accumulation of radioiodine in the thyroid, measured *in vivo*. This test has the advantages of accuracy, minimum time, no discomfort to the patient, and the least need for technical assistance. From a series of over 1,000 diagnostic studies performed, we have found that an uptake of 50 per cent or more of the dose at 24 hours is indicative of hyperthyroidism. From 10 to 40 per cent represents the normal range, and from 0 to 10 per cent is usually seen in hypothyroidism. Some overlapping occurs in the range of 40 to 50 per cent. Low uptakes may be found in the presence of hyperthyroidism when the patient has, within the past two months, received iodide in any form (Lugol's solution, calcium iodide tablets, contrast x-ray media, vioform ointment, or other pharmaceuticals). A high uptake may be found in the presence of normal or low thyroid function in the rare circumstance of iodine deficiency, or in the more common circumstance of excessive propylthiouracil medication, which leads to hyperplasia of the thyroid gland. Except for these known variations, the test is highly reliable and of great diagnostic help in the evaluation of patients for radioiodine therapy.

Indications for Radioactive Iodine Treatment

Considerable discussion has centered about the proper indications for I^{131} treatment of thyrotoxicosis. All patients with diffuse goiters, with or without exophthalmos, are excellent candidates for this form of therapy. Patients with nodular goiters have been treated under certain circumstances. The patient with nodular goiter who is a poor surgical risk because of age or of cardiac, renal, or other complicating disease may be properly treated with I^{131}. The nodular goiter with a recurrence of toxicity after a thyroidectomy may properly be treated with I^{131} and should certainly be so treated if there is any operative damage to the recurrent laryngeal nerve. Finally, the patient who is intolerant to the antithyroid drugs and in whom surgery is not advisable may be treated with radioiodine.

Contraindications for I^{131} Therapy

We have considered pregnancy to be an absolute contraindication to this form of therapy, as the fetal thyroid is developed at about the tenth week. Any suspicion of malignancy in the thyroid, such as a single nodule in a female, any nodularity in a male,

* Presented at the 111th Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1952.

This work was supported in part by the Wisconsin Alumni Research Foundation. Radioiodine was obtained from the Atomic Energy Commission, Oak Ridge, Tennessee.

nodularity in very young people, or any progressive increase in size, makes surgery mandatory. A relative contraindication to I^{131} is a very large gland, in which instance one is likely to find a delayed remission or relative resistance to I^{131} therapy. A final relative contraindication is a substernal goiter, where there is some increased risk of malignancy.

Problems of Dosage with I^{131}

The average total dose of radioiodine required for remission of thyrotoxicosis in our series has been 6.1 millicuries. The largest initial dose given to any patient has been 10.0 millicuries and the largest total dose 41.0 millicuries. In the entire series the average number of doses required to obtain a remission has been 1.4, and the largest number of doses required in any patient has been 8. Fifty-eight per cent of the patients followed in this series have obtained a complete remission on one dose.

Estimation of the proper therapeutic dose of radioiodine has been based on several factors. The most accurate one is the measurement of the uptake of the test dose. The weight of the thyroid is estimated in grams and is subject to considerable variation. It has been found from experience that a concentration of the isotope in the thyroid amounting to from 75 to 100 microcuries per gram of thyroid weight is a conservative and safe figure to employ. If the uptake, the estimated weight of the gland, and the desired tissue concentration of the isotope are known, it is then possible to calculate the oral dosage of radioiodine required to deliver the necessary concentration of I^{131} to the thyroid gland. Because of the variation in sensitivity of goiters to I^{131} radiation, it has been the policy to err on the conservative side in calculating dosage. It would be possible to give enough radioiodine to induce a remission with one dose in 100 per cent of the patients, but this would result in a prohibitively high incidence of myxedema. It is believed preferable, therefore, to select a smaller dosage initially and to treat again those patients who do not obtain a remission with one dose. In this way the incidence of myxedema may be kept to a very low figure.

Results of Radioiodine Therapy

A good result in this series is defined as a satisfactory remission within three to six months, without evidence of recurrence, permanent hypothyroidism, or other complication. Eighty-nine per cent of the patients observed in this series have experienced such satisfactory results and are now euthyroid.

Comment is required on the resistant cases, which total 6.4 per cent of this series. All of these patients have had a remission from their disease, although dosages in excess of 10 millicuries have been required. It is of interest that two thirds of this group of 21 patients had rather large or nodular glands, which may well have contributed to their resistance. It should be emphasized, however, that they are all in satisfactory remission at the present time.

Five-and-a-half per cent of this series experienced a delayed remission, in that slightly over 20 months, on the average, was required to induce a remission. This is an unsatisfactorily long period of time to achieve results; but as this occurred early in our experience, it was largely the result of employment of rather small dosages and cautious therapy.

The recurrence rate of 0.6 per cent in this series is extremely satisfactory, as it indicates an extremely low rate of relapse after six months of complete remission.

Complications accompanying radioiodine therapy of thyrotoxicosis have been surprisingly infrequent. Transient hypothyroidism has been observed in 1.8 per cent of the patients in this series. This has occurred from three to nine months after treatment and has lasted for relatively short periods of time. In these patients the thyroid function has stabilized at a normal level spontaneously. Permanent hypothyroidism has resulted in 2.4 per cent of the patients in the series studied.

Progressive exophthalmos has been observed in 3.9 per cent of the patients, in most of whom (3 per cent) it was present before treatment was given. Hypoparathyroidism, recurrent nerve injury, and thyroid crisis have not been seen in any of the patients in this series.

Failure has been encountered in 7 patients in this series (2.1 per cent), in whom therapy was discontinued for various reasons. Theoretically, there should be no failures if the correct diagnosis of thyrotoxicosis is established and adequate radioiodine therapy given. These cases do not represent

inadequacy of the therapeutic method but only of its application to the individual patient.

Mortality in this series has not been encountered where it could be logically ascribed to the radioactive iodine. One patient was accidentally killed, one died of pulmonary tuberculosis, one died of a coronary occlusion, and one died of unknown causes.

Summary and Conclusions

Experience with 327 patients treated with radioactive iodine and followed at the University Hospitals between May 1947 and September 1952 is reported. Excellent results were obtained in 89 per cent of the patients. Exceptionally large doses were required in 6.4 per cent, resistant cases in whom therapy was nonetheless successful. Delayed remission was experienced in 5.5 per cent of the patients, and a recurrence rate of 0.6 per cent has been found. An incidence of permanent hypothyroidism of 2.4 per cent has been reported. No instances of damage to the parathyroid glands or the recurrent laryngeal nerve have been encountered. In 2.1 per cent of the patients radioiodine therapy was a failure. There has been no mortality ascribable to the administration of radioiodine itself.

Department of Medicine, University of Wisconsin Medical School.

1954 COLLEGE ESSAY AWARD

The board of regents of the American College of Chest Physicians offers three awards to be given annually for the best original contribution prepared by any medical student studying for the degree of Doctor of Medicine on any phase of the subject of diagnosis and treatment of chest disease.

The first prize will consist of a cash award of $250 and a certificate. The second and third prizes will be certificates of merit. The competition is open to all medical students in accredited medical schools throughout the world.

The winning contributions will be selected by a board of impartial judges and will be announced at the 20th Annual Meeting of the American College of Chest Physicians to be held in San Francisco, California, June 17–20, 1954. All manuscripts become the property of the American College of Chest Physicians and will be referred to the editorial board of the college journal, *Diseases of the Chest*, for consideration. The college reserves the right to invite the winner of the first prize to present his contribution at the annual meeting of the college.

Applicants are advised to study the format of *Diseases of the Chest*, noting length of articles, form, and arrangement of illustrations to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than March 15, 1954.
2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside enclosing the name and address of the author.
3. A letter from the dean or chairman of the department of medicine of the medical school, certifying that the author is a medical student studying for the degree of Doctor of Medicine and that the contents of the manuscript represent original work.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Nerve Injuries

Complications which are not related to the physiologic disturbances of anesthetization or of surgical procedures may occur in the patient as an accompaniment to an operation. Unexpected injuries to the unconscious patient upon the operating table are fortunately infrequent, but they happen more often than is generally realized.

Nerve trunks seem especially prone to injury and the brachial plexus is quite commonly involved. Such injuries may result from the improper position of the patient on the table. Since both the surgeon and anesthesiologist have a responsibility for the position of the patient, a review of the mechanisms and contributory factors resulting in damage is presented by the Wisconsin Anesthesia Study Commission from reports of several specific cases.

CASE 49—A presacral neurectomy was performed on a 52-year-old white female for relief of severe pelvic pain due to metastatic carcinoma of the uterus. She was very obese and, during anesthetization for 2 hours 40 minutes, she was placed in steep Trendelenburg position. Ether was the anesthetic agent used and the left arm was abducted for the administration of intravenous fluids and blood. When the patient regained consciousness, she complained of numbness extending along the left forearm and into the hand. After about five days, these symptoms disappeared, and there was complete recovery of sensation.

CASE 50—A 55-year-old male was anesthetized with cyclopropane for a bilateral herniorrhaphy lasting 2 hours 5 minutes. His arms were at his sides, but arm guards were not used. When he awoke he noted numbness along the ulnar side of his left forearm which involved the little finger to such a degree that it could not be abducted. Numbness with occasional tingling and impairment of function persisted for about three months. After one year, his motor power is normal but the patient notices occasional tingling along the ulnar aspect of the forearm.

CASE 51—A 30-year-old male was anesthetized for a laminectomy. After administration of Pentothal Sodium and curare, intubation was accomplished and anesthesia was maintained with ether, using a to-and-fro absorption technic. The patient was placed in the prone position for 2 hours 30 minutes. Both arms were flexed at the elbows and rested on a wide arm board. On the first postoperative day he had difficulty moving his hands and arms and noted tingling sensations. The right arm was more affected than the left. Four days later, fair sensation and power were present in the left arm. Motor function was fair in the right hand but the right shoulder was weak. On the sixth postoperative day, the patient complained of severe pain in the chest. At that time measurement of the arms showed the right to be smaller than the left. On the next day the patient coughed up blood. Diagnoses of pulmonary embolus with infarct of the right lower lobe and bilateral brachial paralysis were made.

On the thirteenth postoperative day there was marked tenderness in the right shoulder. Several days later, a thrombosis was palpable in a vein of the right forearm. Two days later the patient was moving the left shoulder and arm well. Motion in the right shoulder was fair. Therapy consisted of large doses of thiamine and exercise and he was continued on that regime after discharge from the hospital. A period of nine months elapsed before full range of motion and normal sensation returned to the right arm and shoulder.

Discussion

Most nerve injuries are caused by increased tension and pressure. During anesthetization musculotendinous protection is partially or almost entirely absent. Greater muscular flaccidity due to the use of curare

increases the risk of tension. Injury to the brachial plexus, in particular, is essentially one of stretch. Anatomically the nerves are fixed at the transverse vertebral processes by the invagination of the prevertebral fascia and in the arm by the axillary fascia. Any structure which tends to increase the distance between the points of fixation of the nerve may cause injury.[1]

Contributing factors which alter the position of the nerve trunk include: (1) formation of an arch by the attachment of the pectoralis minor to the coracoid process acting as a fulcrum around which the nerve bundle passes; (2) compression of the plexus against the first rib by the clavicle with increased tension in the distal nerve when the arm is placed in extreme abduction and extension; (3) production of a prominence by the head of the humerus which causes stretching when the arm is in external rotation, abduction, and extension; and (4) depression of the shoulder, causing a lateral deviation and extension of the humeral head. The entire plexus is put on stretch when the shoulders are depressed and held in that position by shoulder braces. The nerves are especially vulnerable when the arms of a patient in Trendelenburg position are abducted.[2] Wide abduction of an arm for long periods should be avoided during any operation.

Other nerves in which injuries are fairly frequent are the radial, ulnar, and peroneal nerves.[3] Paralyses of the radial nerve most commonly result from pressure of a sharp edge of the operating room table or an arm board against the back of the upper arm in the area where the nerve curves around the shaft of the humerus. Similar pressure at the elbow may affect the ulnar nerve. Prolonged pressure of the outer aspect of the leg against stirrups in the lithotomy position may cause peroneal damage. Thrombosis of blood vessels, particularly those in the calf, may also occur from undue pressure.

An attempt to prevent injury to nerves should be a prime consideration in the operating room. In general such injury may be avoided if certain specific principles are observed. When the patient is in the Trendelenburg position the arms should be left at the sides. Even mild degrees of tilting should be maintained for as short a time as possible. If at all feasible, extreme positions should be avoided. If the arms are abducted, the range should not be beyond 90 degrees, and the head and neck should be held in a neutral position as much as possible. When a patient is in the supine or prone position, his arms should not be abducted and extended above his head. Elbow guards, properly placed, should prevent an arm from slipping and being pressed against the side of the operating table. Pressure, including that from surgical assistants, should be minimized whenever possible and particularly should not be placed on the legs while they are suspended in stirrups.

The possibility of numerous complications and especially of injuries to nerves should be kept in mind by every member of the operating room staff.

REFERENCES

1. Clausen, E. G.: Postoperative ("anesthetic") paralysis of the brachial plexus, Surgery 12:933–942 (Dec.) 1942.
2. Ewing, M. R.: Postoperative paralysis in upper extremity; report of 5 cases, Lancet 1:99–103 (Jan. 21) 1950.
3. Dhuner, K. G.: Nerve injuries following operations: survey of cases occurring during 6-year period, Anesthesiology 11:289–293 (May) 1950.

CHEST FILM ENLARGEMENTS AVAILABLE

The Wisconsin State Board of Health, in response to a suggestion by the Chest Committee of the State Medical Society, announces that it is prepared to furnish, on request by physicians, copies or enlargements of 70 mm. films taken of their patients in mobile unit surveys throughout the state.

In order to expedite such service the State Board of Health will also serve as a clearing house to locate films taken by other agencies which operate independent units.

Physicians desiring such information or films should communicate with:

Division of Tuberculosis Control
Wisconsin State Board of Health
1 West Wilson Street
Madison 2, Wisconsin

Industrial Nursing Services in Wisconsin

As It Looks to Your State Board of Health

THROUGH teamwork with industrial and family physicians, with plant safety personnel and industrial relations personnel, and with community health and welfare agencies, the nurse in industry helps to provide a broad health service to industrial workers.

As this field is constantly being broadened to include more and more employee groups, the term "occupational health" is becoming more truly descriptive. For example, nursing services are provided for employees in several large department stores in Wisconsin, in some of the larger banks, in newspaper plants, larger hospitals, and insurance companies. Over 550 industrial nurses are working in Wisconsin today in over 300 industrial health services. These nurses need to have a good understanding of occupational health hazards. They must be able to organize and administer smoothly running and efficient health service units.

To meet the demand for nurses with this special training, some schools of nursing are now beginning to include work in occupational health nursing in their basic nursing curriculum, and graduate courses are available.

The work of the full-time industrial nurse generally falls into several areas. Specific duties of the individual nurse will, of course, be shaped by the needs of the workers in her plant and by any special hazards of the industry. She is, first of all, ready to give emergency care for all occupational injuries as authorized by written orders signed by the physician in charge. She gives treatment for occupational injuries and illnesses as prescribed by the physician. She gives emergency care for non-occupational disabilities and sees that the patient is referred to his own physician for further treatment if indicated. The guidance of a physician is essential for the functioning of a good in-plant health service. Management is becoming increasingly aware of the need for and the value of medical direction for plant health services. As a result, more and more business establishments which formerly did not have in-plant medical services are now employing a part-time medical director.

Another area of the industrial nurse's work is concerned with the health conservation program. This, of course, varies from service to service but usually includes assisting the physician with pre-employment and periodic physical examinations. She assists with placement of workers according to physical capacities and guides workers in obtaining corrections of remediable defects. Part of her job is to interview employees who are leaving work because of illness or returning to work after illness.

Because of her daily contact with the workers, the industrial nurse can be intimately aware of the health problems of the individual employee and his worries and anxieties about his own health or that of a member of his family. Since she is the natural confidante of the workers, she can assist them in finding a constructive solution to health and emotional problems and motivate them to seek medical care from family physicians. This results directly in early case finding of adult disease. In such activities she often cooperates with public health agencies concerned with heart disease, diabetes, cancer, tuberculosis, alcoholism, and neurosis. This aspect of her work is also of vital concern to industry in maintaining a healthy and stable work force.

Her share in the health educational program includes the dissemination of health information through individual conferences, bulletin boards, literature racks, and the plant house organ. She assists in the plant safety and sanitation program; she may give or make arrangements for home nursing service; she maintains individual and collective health and accident records for individual counseling and for use in planning health and safety programs.

Setting up such a program in a practical way in small plants (those employing less than 100 persons) is still a largely unsolved problem. The employment of a part-time nurse has helped to solve the problem for some of these plants, and part-time nursing service is steadily increasing. Several Visiting Nurse Associations in Wisconsin are providing part-time service on a contract basis. In some instances two or more plants have

worked out a plan to share the services of one nurse. In any case, cooperation of management, the medical and nursing professions, community agencies, and the employees themselves is needed to find ways to provide such health services.

Assistance in planning for the establishment of a nursing service is given on request by the State Board of Health through the nursing consultant in the Division of Industrial Hygiene. Frequently it is the plant's medical consultant who asks for assistance. A plant visit will be made and information given on what facilities should be provided, what services the nurse can perform, and how much the services are likely to cost. Good nursing practices and the need for medical direction will be explained to management.

When a nursing service is already established, the industrial nursing consultant gives advisory assistance in all phases of the service—keeping records, giving emergency care, obtaining medical direction, and promoting a health conservation program. She also helps the nurse in the field to keep in constant touch with the practices and methods of the most successful nursing services in industry.

Interest in the field of industrial medicine is stimulated by the in-plant clinics sponsored by the State Medical Society and the State Board of Health. Other meetings call attention to particular industrial problems, such as noise hazards. Physicians, nurses, and representatives of management share in these programs. — CATHERINE CHAMBERS, R.N., *Nursing Consultant, Division of Industrial Hygiene.*

CONTINUATION COURSES TO BE OFFERED BY UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

January 7–9: Pediatrics for General Physicians"

Under the direction of Irvin McQuarrie, M. D., professor and head of the department of pediatrics, this course will stress recent advances in the management of common pediatric problems. Along with many other topics of general interest, the care of the premature infant and the therapy of burns will be discussed.

January 25–30: "Neurology for General Physicians"

Emphasis will be placed on the more common neurologic disorders. Director of the course will be A. B. Baker, professor and director of neurology, who will be joined by other members of the Minnesota faculty and the Mayo Foundation and by the following guest faculty members: Madison H. Thomas, M. D., University of Utah; A. Theodore Steegman, M. D., University of Kansas Medical Center; and Adolph L. Sahs, University of Iowa Medical School. An integral part of the course will be the presentation, on January 27, of the annual John B. Johnson Lecture by Andrew T. Rasmussen, professor emeritus of anatomy at the University of Minnesota Medical School.

(See page 661 for other continuation courses offered by the University of Minnesota Medical School).

Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

PRESENTATION OF CASE*

A white four-year-old child was admitted to St. Mary's Hospital on May 21, 1953, with periorbital swelling and ecchymosis. This was first noted by the girl's mother two weeks before and had persisted. Blood studies at another hospital a week before admission were normal except for anemia. The platelet count was normal. Since the onset of the illness, a yellowish discoloration of the skin in the pretibial areas of the legs had been noted. During the past few days the child had been irritable and anorexic and had complained of abdominal pain. A few years previously she had been immunized against pertussis, diphtheria, and tetanus and vaccinated against smallpox. She had been receiving no medication except calcium. Family history revealed that the mother's cousin had leukemia.

Physical examination on admission revealed a well-developed, well-nourished, four-year-old white female who was irritable and uncooperative. Her rectal temperature was 101 F., pulse 150 and regular, respiration 26 and regular. There was moderate periorbital swelling, bilaterally associated with bluish ecchymosis. The teeth were carious. Along the anterior aspects of both legs areas of yellowish discoloration were noted. Slight cervical lymphadenopathy was present. The spleen was questionably enlarged.

Laboratory Examination. Urinalysis revealed 25 to 30 pus cells per high power field; hemoglobin 6.5 Gm.; red blood cell count 2,570,000; white blood cell count 8,750; platelets 112,000. The differential revealed a leukemoid reaction with a slight decrease in platelets and anisochromia, anisocytosis, and poikilocytosis of erythrocytes. There were 11 normoblasts per 200 leukocytes. Differential: 1 per cent myelocytes, 2.5 per cent metamyelocytes, 25.5 per cent stabs, 28.5 per cent segmented neutrophils, 34 per cent lymphocytes. The prothrombin time was 100 per cent of normal. The sedimentation rate was 43 mm. per hour; nonprotein nitrogen 39 mg. per cent; serum bilirubin 0.2 mg. per cent (1 min.), 1.16 mg. per cent (25 min.).

An x-ray of the skull revealed widening of the coronal sutures with a slight increase in the convolutional markings. The calvarium revealed small radiolucent shadows, giving it a mottled appearance. The right frontal diploic markings were accentuated. The chest x-rays were negative.

A needle biopsy of the iliac crest bone marrow was performed on May 25, 1953. The smear showed many smudge cells and an increase in myeloblasts and promyelocytes. On May 25 a small amount of blood was noted in the stool. The patient's heart was regular at 112 beats a minute. Periorbital edema and ecchymosis persisted. The patient was slightly lethargic. Therapy with Aminopterin and cortisone was instituted. She remained febrile (99 to 100.6 F.), but by May 29 she was somewhat more alert and her appetite improved. Small lymph nodes were palpable in the neck. Slight epistaxis occurred. Two days later the patient vomited material which was blood streaked.

Examination on June 3 revealed some bulging of the eyeballs. Soft nodules were palpable in the scalp. They seemed fixed to the underlying bone. The liver was enlarged downward to the umbilicus. A skull x-ray on the next day showed greater widening of the sutures with increased mottling of the calvarium. There was slight demineralization of the dorsum sellae. X-rays of both wrists were negative. Laboratory work remained essentially the same except for clearing of the pyuria. On June 4 the patient was seen by a neurosurgical consultant, who noted marked bulging of the eyeballs, bilateral paralysis of the sixth cranial nerve, choking of the optic disks, and a Babinski sign present bilaterally. The left abdominal reflex was more active than the right.

* From the Departments of Pathology, St. Mary's Hospital, and Marquette University School of Medicine, Milwaukee. Dr. W. W. Busby, pediatrician; Dr. S. B. Pessin, pathologist; and Dr. Joseph Kurtin, resident in pathology.

The patient's general condition was apparently deteriorating and she became more lethargic by June 6. On this day an x-ray of the abdomen revealed a large round mass in the right upper abdomen superimposed on the kidney and liver shadows. The liver was enlarged and the spleen slightly enlarged. A subsequent intravenous pyelogram demonstrated this mass to be above the right kidney flattening the upper pole. The child died June 13. Examination of the peripheral blood had been made 23 times during the patient's 29 days of hospitalization. There was progressive anemia except when the patient was given a transfusion. A few days before she died, the hemoglobin was 4.5 Gm. The leukocyte count ranged between 6,500 and 18,000. The differential smear always contained normoblasts; myeloblasts ranged between 0.5 and 2 per cent and myelocytes between 1 and 2.5 per cent.

Clinical Discussion

Dr. W. W. Busby: This is a very interesting pediatric case which must have taxed one's diagnostic acumen at the time of admission. Since there is no pertinent information regarding the child's past history, we may assume that she was apparently well until she developed periorbital edema and ecchymosis and showed irritability; hence a metabolic disease of serious consequence can be eliminated. There is no history of allergy and there was no itching; therefore the edema was not on an allergic basis. Her urine had many pus cells; and with periorbital edema and irritability, pyelonephritis must be considered. Since there was no albuminuria, we can rule out acute glomerular nephritis. Periorbital edema due to kidney disease is not associated with ecchymosis. The yellowish discoloration of the anterior aspect of both legs, the periorbital edema, and the enlarged spleen and liver would lead one to suspect some type of lipoid histiocytosis. We can rule out metabolic diseases, because the child was well nourished and well developed. She had no diarrhea, thirst, or itching. It would be important to know whether the child had exophthalmos on admission.

Dr. S. B. Pessin: I was interested in the child's blood picture and therefore made a bedside visit. She definitely did not have exophthalmos. She was very pale and had a slight swelling and ecchymosis beneath the lower eyelids. The spleen and liver were slightly enlarged.

Doctor Busby: The blood picture indicates a need for differentiating between severe infection, leukemia, and some type of malignant neoplasm, such as lymphosarcoma, or Hodgkin's disease. Severe infection may cause a marked toxic leukemoid blood picture with anemia. In the clinical summary of this case there is no evidence that the child had a severe infection, such as pneumonia, mastoiditis, or bacteremia. Leukemia is difficult to rule out because of the presence of some blasts. In acute leukemia, blood platelets are markedly diminished; in this case the patient's blood platelet count was normal at another hospital and 112,000 at this admission. The mild lymphadenopathy is not consistent with lymphosarcoma. Hodgkin's disease is extremely rare in patients under the age of 5. X-ray examination of the skull revealed mottling of the calvarium. Leukemia or lymphoblastoma does not produce such mottling of the skull. Mottling of the skull may be found in Hand–Schüller–Christian's disease, but it does not produce widening of the sutures as the x-ray revealed in this case. Evidently there was some neoplastic process involving the dura that caused widening of the sutures. Among the more common malignant neoplasms of children under 5 years of age are retinoblastoma, embryoma of the kidney (Wilms' tumor) retroperitoneal teratoma, and neuroblastoma of the adrenal medulla of the sympathetic nervous system. Retinoblastoma can be ruled out because there were no unilateral eye changes. As the disease progressed, bilateral exophthalmos, nodules in the scalp, and a mass in the right upper abdomen, demonstrated above the right kidney by intravenous pyelogram, developed. I would, therefore, diagnose this case as a neuroblastoma of the right adrenal gland with metastasis to the bones, brain, liver, spleen, kidneys, and lymph nodes. The leukemoid blood picture and severe anemia are the result of metastasis into the bone marrow with crowding out of hematopoietic elements.

Doctor Pessin: May we have the x-ray interpretation?

Dr. Paul S. Epperson: The chest, as you see, is completely negative. The skull reveals widening of the coronal sutures. The other sutures are unaffected. There is a fine radiolucent mottling of the skull. The base of the

skull and the sella appear normal. The convolutional markings are slightly increased. An x-ray of the skull on June 4 revealed increased mottling and increased widening of the sutures. A scout film of the abdomen on June 6 revealed a round mass in the right upper abdomen and a large liver and spleen. This is an intravenous pyelogram and you can see that the tumor mass is above the downward displaced right kidney.

Dr. Joseph Kurtin: The postmortem examination revealed a neuroblastoma of the right adrenal gland with metastasis to the skull, dural sinuses, dura, liver, and lymph nodes. There was extensive subdural and subarachnoid hemorrhage. There were multiple ecchymoses involving the skin of the face, thorax, and legs. The liver weighed 1820 Gm. The hepatic parenchyma had a poorly differentiated architecture. It was mottled with gray-tan neoplastic tissue that fused with the liver tissue and showed no definite delineation. There were also irregular areas of hemorrhage. The spleen weighed 130 Gm. The tumor of the right adrenal gland was well circumscribed and firmly adherent to the diaphragm. It measured 7 cm. in diameter. On cut section it was brownish red and entirely necrotic (Fig. 1). In a few areas a thin rim of yellow adrenal cortical tissue could be discerned. The upper pole of the kidney was flattened, owing to pressure by the adrenal gland tumor. The scalp and calvarium revealed extensive metastasis and tumor spread along the sutures. The dura mater was markedly adherent to the calvarium; both the inner and the outer surfaces were granular, because of multiple neoplastic tissue.

Question: Was leukemia entertained in the differential diagnosis?

Doctor Pessin: Yes, leukemia was definitely considered and the patient was treated with Aminopterin and cortisone. My first impression after studying several smears was that we were dealing with a leukemoid reaction or leuko-erythroblastic anemia. I was quite certain that the blood picture was not that of acute leukemia. There is always pronounced thrombocytopenia in acute leukemia, and this child had 112,000 blood platelets. According to our method of enumerating blood platelets, this count represents about a 50 per cent decrease and is not unusual in leuko-erythroblastosis. Later bone marrow studies revealed many blasts and smudge cells, which are degenerated nuclei. I could

Fig. 1—Tumor of the right adrenal gland, causing pressure flattening of the upper pole of the kidney.

not understand why there were many degenerated nuclei in the marrow smears and none in the peripheral smears. Nevertheless, I grudgingly conceded that the child probably had a subacute leukemia.

One Sunday morning I was asked to see the child. I had not seen her for about two weeks and was surprised to see definite exophthalmos and to find soft nodules in the scalp. I had seen such cases before and it was quite obvious to me that the child had a neuroblastoma of the adrenal gland. On restudying the marrow smears I was able to associate the degenerated and partly degenerated nuclei (smudge cells) to clusters of cells which I found along the margins of the smears. These clusters of cells were interpreted as neoplastic cells. Microscopic sections of sternum examined at necropsy revealed almost complete replacement of the hematopoietic tissue by tumor cells.

This is an interesting malignant neoplasm that occurs almost entirely in young children. About 80 per cent of these neoplasms occur in children under two years of age. The term *neuroblastoma* or *neurocytoma* is gradually being replaced by the term *sympathicogonioma* or *sympathicoblastoma*. It is a tumor of the sympathetic nervous system, but it almost always occurs in or near the adrenal gland. Because of the differing modes of metastasis and its varying clinical manifesta-

tions, early investigators classified two forms of metastasis. One type, classified by Ewing and others as the Hutchinson type, arose from the left adrenal gland and produced extensive skeletal metastasis and exophthalmos. The second, or the Pepper type, arose from the right adrenal gland and metastasized mainly into the liver. These types are no longer stressed, since the records now reveal that the extent and location of metastasis vary regardless of whether the tumor arises from the left or right adrenal glands. Our case substantiates the preceding statement, since this child had extensive metastasis into the liver. The liver was larger than that of the average adult. According to the early investigators, this type of metastasis would be considered the Pepper type. However, the marked exophthalmos and extensive metastasis into the skull would be characteristic of the Hutchinson type. It is interesting to note that one of the first objective findings in some of the early cases was ecchymosis in the eyelids, which was noted in our case.

Question: What did the lungs reveal at postmortem?

Doctor Kurtin: The gross appearance was that of a lobular pneumonia. Microscopically, however, the small area of consolidation revealed metastasis of a neuroblastoma.

AMERICAN COLLEGE OF SURGEONS OFFERS SCHOLARSHIPS IN FIELD OF RESEARCH

The board of regents of the American College of Surgeons has announced the establishment of scholarships in the field of research for young men seeking a career in academic surgery who have recently finished or are in the final months of their residency training program.

In May the college established one of these scholarships. It is planned that additional scholarships will be added through the efforts of Fellows and various organizations interested in this project.

Candidates must obtain the approval of the chairman of the department of surgery and dean of the same medical school and the authority of an executive officer of the university making the proposal.

Successful candidates will receive $20,000 over a three-year period, to be divided as follows: $6,000 for the first year, $6,000 for the second year, and $7,500 for the third year. The institution or medical school sponsoring a successful candidate may supplement this amount with the permission of the committee on selection of the American College of Surgeons.

Medical schools or institutions supporting the nomination of a candidate will be required to provide a satisfactory place to work, with adequate facilities, as well as funds with which to support necessary research.

The candidate and the institution supporting his nomination are asked to supply the college with a planned program for the nominee. On completion of the research scholarship, the medical school or institution supporting the candidacy of the nominee is expected to absorb the research scholar into its faculty and to support him on a full-time basis with its own budget.

Inquiries may be addressed to the Research Scholarship Committee, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Income Tax Provisions Affecting the Medical Profession

I. FEDERAL

Introductory

THE advantages of preparing income tax returns correctly and of taking full advantage of all permissible deductions and exemptions are at least twofold. One is the saving of the physician's time. It is costly for him to have to submit needlessly to interrogation by interview, letter, or audit. Second is the reduction in taxes, and the avoidance of needless later penalties and interest.

A physician will find it economical, from the standpoint of time and money to turn income tax matters over to his attorney and accountant, so that he may concentrate in his own professional field.

No effort has been made in this article to consider the special problems which arise in medical partnerships of two or more physicians, or in connection with the operation of larger units of medical practitioners, including clinics. In the first place, units of that size ordinarily employ an attorney and a consulting accountant. Second, although their problems in the main follow those of individual physicians, and the text which follows is generally applicable to them, certain of their problems, such as the fixing of shares of net income, donations and capital gains, are dependent upon individual agreements, and cannot be treated in a general article of this nature.

Those who desire more detailed information than is possible in a short general article of this type will find the following helpful: "Physicians Federal Income Tax Guide," by Campbell and Liberman, 1953 edition, published by Doniger & Raughley, Inc., Great Neck, New York, price $2.50. A new edition of this guide will not be printed for 1954. A supplement on current tax changes will, however, be sent automatically to all purchasers of the 1953 edition. If you did not buy the 1953 edition, both it and the supplement can be purchased for $2.50. Also helpful, as soon as the 1954 edition is available, is "Your Federal Income Tax," which may be ordered from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., price 25 cents. The informational pamphlet which can be obtained from your post office or from the Director of Internal Revenue at Milwaukee about the middle of December should also prove helpful, although it is less detailed than either of the other two.

Also available is "The Doctor's Tax Letter," published monthly by the Doctor's Tax Letter, Inc., 2000 No. Lincoln Park West, Chicago 14, Illinois. Each letter deals with a different phase of taxes affecting doctors. The yearly cost is $10.

1953 Court Decisions

Expenses of a doctor's attendance at postgraduate courses are deductible as business expenses on the doctor's federal income tax returns as a result of the case of *Coughlin v. Commissioner of Internal Revenue*, 203 Fed. 2d 307 (1953). In this case the United States Court of Appeals held that the expenses which a law partnership member incurred for tuition, travel, board, and lodging while attending a postgraduate institute on federal taxation, designed to keep lawyers informed as to changes in tax laws and the significance of current court decisions, were deductible. This decision reversed a long standing rule of the Treasury Department prohibiting the deductibility of postgraduate education expenses. The significance of the decision is summarized in the following informal opinion rendered to the American Medical Association by its tax counsel, and reprinted in the *Journal of the American Medical Association* in Volume 153, No. 9, (October 31, 1953) on page 838:

"The decision of the Circuit Court is not confined to lawyers. It equally applies to the practicing physician who attends postgraduate courses which are similarly designed to refresh his medical knowledge and to keep him informed of recent medical developments. Therefore, in computing his federal income tax a doctor may deduct the expenses of his attendance, namely, the cost of his tuition, travel, board, and lodging.

"However, it is by no means clear that the court's decision covers attendance at postgraduate courses which are designed to advance the doctor into a new area of his profession. For example, there is a good deal of doubt whether a general practitioner may deduct his expenses in attending a postgraduate course in order to specialize in surgery. But this would be the unusual case. Normally, a doctor attends a postgraduate course relevant to the field in which he is practicing, and all the expenses which he so incurs are deductible by him."

1954 Withholding Tax and Social Security Changes

Under present law, federal income taxes will be reduced approximately 10% for most taxpayers beginning with the year 1954. This change will be reflected in the amounts withheld from employees' salaries beginning January 1, 1954. New withholding tax tables will be issued by the government prior to that time. The lower rates will also result in reduced payments on estimated taxes, beginning in 1954.

Effective January 1, 1954, Social Security taxes are increased to a total of 4%; the shares of employers and employes are each increased from 1½% to 2% of wages paid.

It is possible that Congress may prevent either or both changes mentioned above from taking effect. Congressional developments should therefore be watched.

Individual Federal Income Tax Calendar

1954

15th of each month (except January, April, July, and October). Pay income taxes withheld on wages to a government depository if more than $100 in combined withholding and social security taxes (entire 4 per cent) was withheld during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return is filed on or before January 31, April 30, July 31, and October 31.

January 15. Pay final installment of estimated 1953 tax. Also final date for amending 1953 declaration of income, or filing a final return in lieu thereof. If a 1953 income tax return is filed by this date, it may incorporate any previous underestimate of 1953 income, and no penalty which would otherwise be imposed for underestimating such income will have to be paid if the full balance of the 1953 tax is forwarded with the return.

January 31. Due date of employer's return of income tax withheld and Social Security tax for last quarter of 1953; also for Form 940 by employers of 8 or more. Also deadline for withholding and Social Security tax payments. The employer must furnish to each employe whose wages exceed the amount of one withholding exemption during 1953, a written statement, Form W–2, showing the wages paid during 1953 and the amount of tax withheld on such wages.

February 28. Due date of information returns showing interest or rent payments of $600 or more, and wage payments of that amount not subject to withholding.

March 15. The following are due on or before this date:

(1) Due date of individual income tax return for 1953, for those whose tax year ends December 31, 1953, unless made on January 15. Any excess of tax shown on this return over tax withheld and amounts paid on 1953 tax is due on this date.

(2) Declaration of Estimated Tax for 1954; one quarter of estimated tax payable on this date.

(3) 1953 partnership and corporation income tax returns where the income tax year ends December 31, 1953.

(4) Gift tax return; and any gift tax due thereon.

April 30. Due date of employer's returns of income tax withheld and Social Security tax for first quarter of 1954. Also deadline for withholding and Social Security tax payments to accompany returns.

June 15. Due date of second installment of estimated 1954 tax; date for filing Declaration of Estimated Tax where requirements were first met between March 1 and June 2. Amendment of Estimate previously made may be filed at this time.

July 31. Due date of employer's return of income tax withheld and Social Security tax for second quarter of 1954. Also deadline for withholding and Social Security tax payments to accompany returns.

September 15. Due date of third installment of estimated 1954 tax; date for filing Declaration of Estimated Tax where requirements were not met until a date between June 1 and September 2. Amendment of Estimate previously made may be filed at this time.

October 31. Due date of employer's return of income tax withheld and Social Security tax for the third quarter of 1954. Also deadline for withholding and Social Security tax payments to accompany returns.

1955

January 15. Pay final installment of estimated 1954 tax. Final date for amending 1954 declaration of estimated tax, unless taxpayer prefers to file his 1954 income tax return by that date.

Withholding Taxes and Declaration of Estimated Tax

Employers Required to Withhold. Every physician employing persons for wages which are subject to the withholding tax must withhold from such wage payments an amount computed in accordance with the formula or tables provided by the Commissioner of Internal Revenue upon request. The amount so withheld must be paid by the fifteenth of the following month to a government depository (a designated bank) if a total of more than $100 in combined withholding and social security taxes (entire 4 per cent) was withheld from all employees during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return of taxes withheld is filed on or before January 31, April 30, July 31, and October 31.

Physicians should obtain from each employe an Exemption Certificate Form W–4 duly signed by the employe. This form should be obtained at the time employment begins. An amended form should be signed and filed with the employer whenever the employe's exemption status changes. If no certificate is furnished the employer, no exemption is allowed in computing the amount of tax to be withheld.

Wages Subject to Withholding—Exceptions. Wages subject to withholding include all remuneration paid to an employe, whether designated as salary, wages, fees, commissions, et cetera, and whether paid in cash or in something other than cash.

Excluded from "wages" and not subject to withholding are the following:

(1) Fees paid to public officials, such as notaries public and sheriffs.

(2) Compensation for services as a member of the military or naval forces of the United States in cases in which the pay is exempt because of combat zone service.

(3) Remuneration for agricultural labor.

(4) Payments for domestic service in a private home or college club or a local chapter of a college fraternity or sorority.

(5) Compensation for casual labor not in the course of employer's trade or business.

(6) Remuneration for services rendered as a minister.

(7) Professional fees of a self-employed physician or other person.

Statement of Taxes Withheld. The employer must furnish annually to each employe Form W–2, in duplicate, showing the amount of taxes withheld from his pay even though such amount be zero, if the wages paid to the employe exceed the amount of one withholding exemption as shown by the federal tables.

Filing Declaration of Estimated Taxes. Every physician must file a declaration of his estimated federal income taxes for the new year if:

(1) His gross income not subject to withholding tax is expected to exceed $100, and his gross income will be $600 or more.

(2) His gross income from wages subject to withholding can reasonably be expected to exceed $4,500 plus $600 for each exemption in addition to his own.

This estimate for 1954 must be filed by March 15, 1954. and amended estimates may be filed on June 15, September 15, and January 15 following.

A husband and wife living together may file a single declaration on which they will be jointly liable.

Penalties. Penalties are provided for failure to file Declaration of Estimated Tax and failure to pay installments when required to do so.

For underestimating tax by more than 20 per cent (33⅓ per cent for farmers) the penalty is 6 per cent of entire shortage in estimate, but not more than the amount by which the estimate falls short of 80 per cent of the tax (or, in the case of farmers, 66⅔ per cent of the tax).

This penalty will not apply if (*a*) the estimated tax is computed on last year's income at this year's rates and exemptions, and is paid on time in equal quarterly installments, or (*b*) is paid ahead of time, or (*c*) an income tax return is filed and the full balance of the tax paid on or before January 15 of the succeeding year.

General

Joint Returns. Joint returns by husband and wife may again be filed for the calendar year 1953. Such split income feature is limited to spouses who live together and have the same tax year. Divorced or legally separated persons may not file such returns. Should one spouse die during the year who had the same tax year as the survivor, the survivor and the decedent may file a joint return and enjoy the advantages thereof as though both had lived. Husband and wife may file a joint return even though one of them has no gross income or deductions. It should be remembered that the signatures of *both* spouses are required on a joint return. *Each* spouse is jointly liable with the other, and also individually liable for part or all of the tax, as the government may elect.

When a Joint Return is Advisable. The filing of a joint return is optional just as it was in prior years. In almost all cases in which husband and wife have a combined net income over $2,000, after deductions and exemptions, it will be advantageous to file a joint return. One exception might be where both spouses have substantially the same income. A second exception might arise where 5 per cent of the combined incomes would be insufficient to cover the medical expenses of both spouses, although maximum advantage might be enjoyed on separate returns.

Where each spouse has taxable gain or deductible loss from sales or exchanges of property, it may **not** be advantageous to file a joint return despite the income-splitting provisions. The only way to be sure whether a joint or separate return is more advantageous is to compute the tax both ways where the above exception appears.

Types of Returns. The federal government provides the following three types of personal income tax returns: Short-Form 1040, Form 1040A, and Long-Form 1040. In some cases no choice is open to the taxpayer in selecting a particular form over others. There are situations in which a choice is open, however, as appears from the text following.

The paragraphs following are taken from a pamphlet distributed by the United States Treasury in connection with the preparation of 1952 returns. Its language is simple and helpful.

"**Income Less than $5,000.** 1. *Form 1040A.*—This is the simplest return of the three. If you file this form, you do not need to figure your own tax. From your answers to the questions, the Director will figure your tax for you, and send you a bill or a refund. If your total income was less than $5,000 and consisted entirely of wages reported on Withholding Statements (Forms W–2), or of such wages and not more than $100 total of other wages, dividends, and interest, you may use Employee's Optional Income Tax Return (Form 1040A). If (1) you had any income from other sources, such as annuities, rents, royalties, a business or profession, farming, transactions in securities or other property, partnerships, estates, and trusts, or (2) if you claim the status of head of a household, you may not use Form 1040A but must file your return on Form 1040. You cannot deduct travel or reimbursed expenses from your wages if you file Form 1040A.

"2. *Short-Form 1040.*—Form 1040 may be used either as a short form or as a long form. The short form is simpler than the long form. It differs from Form 1040A in that (a) you must find your own tax; (b) you may include income from sources not eligible for Form 1040A; and (c) you may deduct travel and reimbursed expenses from your wages. Therefore, if your income was less than $5,000 and you do not desire to itemize nonbusiness deductions

(contributions, interest, etc.), find your tax from the table on the back of the form, tear off the first sheet and file it as a short form.

"3. *Long-Form 1040.*—If your nonbusiness deductions are more than 10 percent of your income, you will ordinarily save money by itemizing your deductions on Long-Form 1040. You will then figure your tax according to the computation on page 3, and file the entire form, which is called a long-form return. If your nonbusiness deductions are so close to 10 percent that you are in doubt which is the better form, try both the short form and the long form to make sure.

"Income of $5,000 or More.—If your income was $5,000 or more, you must use Long-Form 1040. However, in that case, you can either take a standard deduction or itemize and claim your actual deductions. You should compare your actual deductions with the amount the standard deduction allows you. If actual deductions exceed the standard deduction, you will save tax by electing to itemize them. If you are single, or if you are married and file a joint return, the standard deduction is 10 percent of your income but not more than $1,000. If husband and wife file separate returns, and each had income of $5,000 or more, the standard deduction is a flat $500 for each."

Your attention is also directed to page 649, under the heading "Adjusted Gross Income Deductions" for a listing of those items which may be deducted even though the optional standard deduction is elected.

Personal Exemptions. Personal exemptions and credits for dependents are $600 per person. It should be noted that in the case of dependents the credit allowed the taxpayer is $600 but it may be taken for dependents whose income is less than $600. No credit for a dependent may be taken where the latter has filed a joint return with a spouse, no matter how much support is provided.

A special exemption of $600 for each taxpayer over 65 is permitted, *in addition to* the ordinary personal exemption of such person. The Act also allows an *additional* exemption of $600 if the taxpayer's *spouse* is over 65, or attains such age during the year, provided such spouse is not the dependent of another taxpayer. Any person attaining age 65 on or before January 1, 1954, may claim this additional exemption for the year 1953.

An additional $600 exemption for the blind is also allowed. It should be noted that where a person is over 65, or is blind, and is a dependent of a taxpayer *other than* a spouse, *no* additional exemption is allowed such taxpayer. As an example, a husband whose wife is over 65, blind, and dependent upon him for support, may claim a triple exemption of $1,800 for such wife. If a son were supporting the wife instead of the husband, and the facts were otherwise the same, the son could claim only $600 exemption for his mother.

Head of Household. An unmarried person who is "head of a household" is taxed at a lower rate than other unmarried persons, but at a somewhat higher rate than married couples who file a joint return. This is accomplished by using a separate table of tax rates which apply only to heads of households.

A head of a household is any individual who is *not married* at the close of his taxable year, but maintains as his home a household which also constitutes the principal place of abode, as a member of such household, of:

1. His children, their descendants, or his stepchildren.
2. Any other person who is a dependent of the taxpayer.

In the case of the taxpayer's children, the descendants, or stepchildren, provided such persons be unmarried, it does not matter if such persons have income over $600 or more, or if the taxpayer did not contribute more than half of such persons' support. However, if any of such persons are married, they must first qualify as a dependent of the head of the household. For a discussion of who are dependents see the following heading entitled "Dependents."

The head of a household need *not* add the income of relatives living in the household to his own. Furthermore a head of a household, in addition to being able to use the lower rates, will still be entitled to take *all* of the exemptions for dependents that he otherwise would be entitled to. The head of the household must furnish not less than one-half of the cost of maintaining the household.

Dependents; Wife. The age of the dependent or his ability to support himself is not material. A dependent means one of the following persons over half of whose support for the calendar year in which the taxable year of the taxpayer begins was received from the taxpayer:

(a) A son or daughter of the taxpayer or a descendant of either.
(b) A stepson or stepdaughter of the taxpayer.
(c) A brother, sister, stepbrother or stepsister, half-brother or half-sister of the taxpayer.
(d) The father or mother of the taxpayer, or an ancestor of either.
(e) A stepfather or stepmother of the taxpayer.
(f) A son or daughter of a brother or sister of the taxpayer.
(g) A brother or sister of the father or mother of the taxpayer.
(h) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer.

"Brother" and "sister" include a brother or sister by the half blood. A legally adopted child is considered a child by blood.

A taxpayer cannot claim exemption for a niece or nephew by marriage even though he has furnished more than one-half the support of such person or persons, unless his spouse joins in a joint

return. To take an example, a husband who furnishes more than one-half the support of a niece or nephew of his wife may claim an exemption for such niece or nephew only if his wife makes a joint return with him. The exemption will be allowed in such case even though the wife did not furnish the support and even though she did not have any taxable income.

The term "dependent" does not include any individual who is a citizen or a subject of a foreign country unless such individual is a resident of the United States, Canada, or Mexico.

A taxpayer is allowed a credit of $600 for a spouse who was not legally separated from him on the last day of the taxable year, although she is technically *not* a dependent.

No exemption for a dependent is allowed if the dependent's gross income was $600 or more, or if the dependent is married and has made a joint return with his or her spouse for the calendar year in which the taxable year of the taxpayer begins.

The fact that the dependent was not in existence throughout the year is immaterial. Thus, if a child of the taxpayer supported by the taxpayer is born or dies during the taxable year a full exemption is allowable for such child.

In like manner, a taxpayer who is married during the year and claims an exemption for his wife is entitled to a full exemption for her for that year, if at the close of his taxable year (ordinarily December 31) he was still married to such spouse, or, if she died during the tax year, he was married to her on the date of her death.

Alternative Tax. If there is an excess of combined net long term capital gains over combined net short term capital losses, the law provides an alternative method for computing the tax. Every dollar of such excess is taxed at a 50 per cent rate, and in some situations this may be lower than the tax regularly computed on Form 1040.

The use of the alternative method will never result in a tax liability lower than that regularly computed on Form 1040, unless *one-half* of the net income, less *one-half* the exemptions of husband and wife who make a joint return, exceeds $14,000. In the case of an unmarried person, or the separate return of a married person, the alternative method will never result in a lower tax liability, unless the net income, less exemptions, exceeds $14,000. In the case of a head of a household, the net income less exemptions must be $20,000.

These figures are only turning points, and the computations must be made by competent people, who will know whether the alternative tax increases or decreases the total tax liability.

For further consideration of this question see the subsection of this article beginning on page 647. entitled "Capital Gains and Losses."

Compensation for Services of Children. Compensation for services rendered by a child shall be included in the gross income of the child and not in the gross income of the parent. The child is considered a separate taxpayer subject to the regular requirements as to filing and is entitled to a separate exemption for normal tax and surtax.

The parent or guardian of the child must file the required return where the child is unable to do so. Liability for the tax on compensation earned by the child is placed on the parent if not paid by the child.

Where the gross income of the child for the calendar year is $600 or more the parent is not allowed to consider the child a dependent.

Income

Items Reportable as Income. Broadly speaking, income includes all wealth which comes into the taxpayer's hands, other than as a return of capital. It is not even necessary in all cases that the income be *actually* received before the close of the taxpayer's reporting year for him to be obligated to report receipt of a certain item as income. Thus, salaries or bonuses are sometimes set up in a given year, and are made available to the taxpayer, although not paid to him until after the first of the following year. He would nonetheless have to report such items ordinarily because of the availability of such income to him. This is known technically as "constructive receipt" of income.

The same general rule would hold for dividend checks mailed before the close of the tax year, although not actually received by the taxpayer until a day or two after the first of the following year.

The following items, which have some application to physicians as a group, are reportable as income:

1. Compensation for professional services, whether in the form of salary, personal earnings from the practice of medicine, or the share of profits from a professional partnership between two or more physicians. The salary paid by a branch of government must also be included as income; as must a teaching salary, lecturing fees, and the like. Physicians sometimes have income for personal services of a nonprofessional character such as executor fees for handling an estate, or directors' fees received from a corporation as compensation. Such items are likewise reportable in gross income.

2. Earnings from investments. The most common of these would consist of cash dividends on corporate stock; interest from loans, bank savings, or bonds of business corporations; interest on U.S. savings bonds issued after March 1, 1941; net rental income from buildings and lands.

3. Income in the form of interest on life insurance proceeds held by the insurance company under an agreement to pay interest is includable in gross income. If a life insurance policy is surrendered by the insured for a lump sum in excess of total net premiums paid, the insured person realizes income to the extent of such excess over his cost.

As to annuities, or a matured endowment policy paid in installments under an option selected by the insured before the endowment matured, 3 per cent of the cost of such annuity or endowment is includ-

able annually in gross income, if that amount or more is received in payments in a particular year. The remainder of the income from either source for a particular year is excluded from gross income. When the aggregate amount excluded equals the cost of the annuity or endowment, the entire amount received thereafter must be included in gross income.

If any part of the survivor's interest in an annuity contract was included in the gross estate of a decedent for federal estate tax purposes, the survivor must include in gross income an amount equal to 3 per cent of the *estate tax* valuation instead of 3 per cent of the *actual cost* of the annuity contract, as was formerly the case. In the case of a physician who was a joint annuitant with his wife, this could be an important saving to whichever one of them survived the other.

4. In addition to items strictly classified as "income," one is also obligated to report ordinary gains and losses on the sale of property owned by the taxpayer in addition to capital gains and losses. The latter subject is separately discussed on this page. The subject of gains or losses, and when taxable or deductible as the case may be, is perhaps one of the most technical fields of federal tax law and should be placed in competent hands. Otherwise a tax may be paid needlessly in one instance, and penalties and interest needlessly incurred in another.

5. Income from royalties or from a farm or other business in which a physician is interested apart from his professional practice.

Items Not Reportable as Income. The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; damages received on account of personal injuries or sickness, whether paid by an insurance company or as a result of successful litigation; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations if the obligations were issued prior to March 28, 1942; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income).

Also, corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned income received from sources without the United States by a citizen who is a bona fide non-resident for certain stipulated periods of time except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in wartime.

Interest on obligations of a state or political subdivision thereof is excluded from taxation.

Certain interest on United States government obligations is fully exempt from tax, while some types of interest are exempt from normal tax and partially exempt from surtax. In general, if the United States obligation was issued prior to March 1, 1941, interest may be wholly or partially tax-exempt. In some instances the terms under which the obligation is issued determine taxability of the interest.

Dividends on share accounts in federal savings and loan associations, if the shares were issued prior to March 28, 1942, are exempt from normal tax, but not from surtax.

The exclusion from reportable income of pay of United States servicemen for duty in combat zones applies until December 31, 1953. The exclusion also covers the pay of servicemen received for any month during any part of which the individual was hospitalized, as a result of wounds, disease or injuries incurred while serving in a combat zone after June 25, 1950, provided that during all of such month there were combatant activities in some combat zone.

Capital Gains and Losses. Capital gains and losses are classified as follows:

(1) *Short-term* capital gains and losses are those resulting from the sale or exchange of capital assets held not more than six months.

(2) *Long-term* capital gains and losses are those resulting from the sale or exchange of capital assets held more than six months.

It is important to note that a net capital loss is deductible against ordinary income only to the extent of $1,000. The portion of the net capital loss which is disallowed, because it exceeds $1,000 in a given year, may be carried over to the five succeeding years to be applied against any future capital gains and also against other ordinary income up to the $1,000 maximum in each such future year.

The entire gain or loss from a sale of improved business real estate held *less than six months* is treated as an ordinary gain or loss, with 100 per cent recognition for income tax purposes. If such property is held for more than six months, and if the gains exceed the losses from such property, the gains or losses are treated as though long term gains or losses. If the losses exceed the gains, both are treated as ordinary gain or loss.

If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness, are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

Individuals not involved in the sale or exchange of any capital or other assets during 1953 need

have no concern over these capital gains or losses provisions.

Capital gain treatment is denied on sales or exchanges of depreciable property between a husband and wife, or between an individual and his controlled corporation. Any gain on sales or exchanges falling within the above situation will be taxed as ordinary income, at the maximum rate or rates applicable.

Installment Sales. Where a physician sells real estate, or where he makes a sale of personal property, such as his medical practice, or some other property which he is not in the business of selling regularly, and there is a profit on such sale, it is possible to spread that profit over a period of years, with consequent reduction in the income tax payable on such sale, assuming that he is otherwise in a favorable income position and so continues during the years when the balance of the payments are being made to him.

To gain such advantage it is required that the initial payment does not exceed 30 per cent of the selling price. The remainder, of course, can be payable in whatever manner the parties agree in subsequent years. As a general proposition where the profit on such a sale is substantial, it would probably be advisable to spread payments over three to five years, especially where the physician may not need the money at one time, and is secured on the balance.

In the case of personal property such as accounts receivable or a piece of machinery, it is also a requirement that the selling price must exceed $1,000.

There are two possible disadvantages which may diminish or eliminate the intended advantages of installment sales. One is that reduced income or deductible losses during one or more of the years of collection of an installment sale might be sufficient to offset part or all of the profit of the sale. A second possibility is that future Revenue Acts might eliminate the tax advantages now permitted in reporting long-term capital gains.

Nobody can foresee the future actions of Congress. It can only be said that to date those who have reported sales on an installment basis have in many cases derived a tax advantage from doing so. The matter should be carefully weighed by an attorney or an accountant.

Sale or Exchange of Residences—If a taxpayer sells property used as his principal residence and purchases a new residence within one year before or after the date of sale, a gain will be recognized only to the extent that the selling price of the old residence exceeds the cost of the new. The cost basis of the new residence must be reduced by the amount of nonrecognized gain.

Example 1: Mr. Brown sold his old home in March, 1953, for $16,000, which cost him $10,000 in 1942. In June, 1953, he purchased a new residence for $18,000. None of the $6,000 gain on his old residence need be reported. However, the cost basis of the new residence must be reduced by $6,000 (the amount of the nonrecognized gain on the old home), thus making its cost basis $12,000.

Example 2: Mr. Brown sold his old home in March, 1953, for $21,000, which cost him $15,000 in 1942. In June, 1953, he purchased a smaller home for $17,500. Of the gain of $6,000 on the sale of his old home, $3,500 is recognized, this being the amount that the sales price of the old home exceeds the cost of the new home. The $3,500 will be treated as a long term capital gain. The cost basis of the new home will be reduced by $2,500 (the nonrecognized part of the gain) to $15,000.

Where a new residence is constructed, construction of the new home must begin prior to the expiration of one year after the date of the sale of the old residence, and it must be used as the taxpayer's residence within 18 months after date of sale.

If either the old or new residence is used in part for business or rental purposes, the selling or cost prices must be allocated between residential and nonresidential uses.

The nonrecognition of gain rule applies only to one residence, the last so used, for each one year period.

The law relating to sales and exchanges of residences is a complex one. Different or modified rules apply, for example, in cases of construction instead of purchase of the new residence, or if only a portion of a multiple unit building is occupied as a residence. Special rules also apply if more than one residence is sold in one year. It is recommended, therefore, that a lawyer and accountant be consulted in all cases involving residence sales and exchanges.

Accounts Receivable Rule. Certain types of taxpayers, including physicians, are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $25,000 on his accounts receivable records in a given year, but collects only $15,000 of it in cash during that year. He also collects in cash during that same year the further sum of $5,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $20,000, while his gross income on an *accrual* basis is $25,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is *actually received* in accounts, notes, interest, rent and similar items, because his losses from these sources are so much higher than those of a commercial concern. Physicians recognize this fact from experience, and almost universally report on the cash basis.

Upon a physician's death, the accounts and notes receivable outstanding at his death are not treated

as income excepting as they are collected, where the deceased person reported his income on a cash basis. At the time of collection such income is taxed to the estate or to the beneficiary of the estate, depending upon the recipient.

It is important for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not leave on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an account is bad and getting an allowance for it, thereby compelling payment of a tax on an account which neither you nor your heirs will ever collect.
2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against the reserve all accounts known to be in this classification.
3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

This rule is limited to the federal income tax, does not affect the state income tax due, and does not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

Deductions

Deductions which will be allowed on the federal tax return are discussed in detail under the heading "Explanation of Deductions," beginning on page 651.

Allowable deductions are of two types: those which can be deducted as expenses in arriving at the net amounts of income set forth on pages 1 and 2 of the return, and those which can be deducted only on page 3 of the return. Hereafter in this article, the former are designated "Adjusted Gross Income Deductions" and the latter as "Page 3 Deductions."

Optional Standard Deductions. In lieu of page 3 deductions the "standard deduction" may be used. Some physicians may find this to their advantage. See page 645 of this article, first column, under the heading "Income of $5,000 or More." Bear in mind, however, that Adjusted Gross Income Deductions may be claimed whether page 3 deductions are itemized or the optional standard deductions used.

Adjusted Gross Income Deductions. Of the deductions listed in a later paragraph, under the heading "Explanation of Deductions," those which fit into any of the five categories set forth below should be deducted from gross income to arrive at adjusted gross income, and only the net income should be shown under items 2, 3 and 4, page 1 of the return (Form 1040).

In cases where the deductions are from wages, salaries, bonuses, etc., received from an employer, a separate rider should be attached to the return showing (a) gross compensation; (b) the detailed deductions; and (c) the net amount which will be carried to line 2, page 1, of the return.

In cases where the deductions are from income *other than* compensation for employment, as where a physician practices alone, the detailed deductions should be set forth on page 2, schedules C or F.

Deductions which do not fit within any of the five categories set out below *must* be deducted on page 3 of the return.

The five categories of expenses deductible from gross income on pages 1 or 2 are:

(1) Deductions attributable to the trade, business or profession carried on by the taxpayer, if such trade or business does not consist of the performance of services by the taxpayer as an employee.

(2) Deductions which consist of expenses of travel, meals, and lodging while away from home, paid or incurred by the taxpayer in connection with the performance by him of services as an employee.

(3) Deductions (other than expenses of travel, meals, and lodging while away from home) which consist of expenses paid or incurred by the taxpayer, in connection with the performance by him of services as an employee, under a reimbursement or other expense allowance arrangement with his employer where such expenses exceed the reimbursement. (If the reimbursement exceeds expenses, the excess is reportable income.)

(4) Deductions attributable to property held for the production of rents or royalties.

(5) Deductions which consist of certain losses from the sale or exchange of property.

An employee, it should be noted, can deduct expenses in arriving at the net amounts of income set forth on pages 1 and 2 of the federal return, *only* if those expenses fit within the term "traveling expenses", or are reimbursed expenses. All other allowable deductions of employees *must* be set forth on page 3 of the return.

The significance of allowing the expenses to be deducted in arriving at the net amounts of income set forth on pages 1 and 2 of the return lies in the fact that these deductions may be claimed even though the Optional Standard Deduction be also claimed; whereas, deductions which must be set forth on page 3 of the return are deductible *only* if the Optional Standard Deduction is not claimed. The proper classification and separation of allow-

able deductions, as above suggested, will in some cases result in a reduced tax liability.

Deductible "Business Expenses" of Employees. Generally, in order for expenses incurred by an employee taxpayer in carrying on his occupation to be deductible from compensation, (a) the employee must be required, by the terms of his employment, to bear such expenses himself, (b) the expenses must be related to the employer's business, and (c) they must be reasonable in amount.

The basis for requiring an employee to bear the expense lies in the rule that one taxpayer cannot deduct expenses of another.

All allowable "business expenses" of employees must be deducted from adjusted gross income to arrive at net income (page 3 of the return), except as set forth on page 649 of this article, under the heading "Adjusted Gross Income Deductions."

Index to Deductions

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

Automobiles, 1.
- Depreciation.
- Driver, 1.
- Insurance, 1, 11(b).
- Maintenance.
- Repairs.

Bad debts, 2.

Bandages, 4.

Depreciation.
- Automobiles—20 per cent annually on cost price, 1.
  - Classification includes snowmobiles and other motive equipment.
- Instruments, 4.
  - 10 per cent annually on cost of surgical instruments and general equipment; 10 per cent on cost of x-ray equipment. Rate must be reasonable.
- Medical library, 3.
  - 10 per cent annually of cost price.
- Office building, 5.
- Office equipment, 5.
  - 10 per cent annually of cost price (average).

Dues, 7.

Equipment, 4.
- Both long and short-lived.

Fire losses, 11(d).
- Professional equipment and other property.

Income, what is, 646

Income, what is not, 647

Installment sales, 11(9).

Instruments, 4.

Insurance premiums.
- Automobile, 1.
- Hospital and surgical, 11(f).
- Malpractice, 11(b).
- Professional equipment, 11(b).

Interest paid 11(h).

Laboratory materials and expenses, 4, 11(c).

Legal expense, 11(a).

Library, 3.

Licenses, 8.

Medical expenses, (personal and family) 11(f).

Medical meetings, 9.

Medical Society group health and accident annual premium, deduct $17—See 11(f).

Medical supplies, 4.

Office expenses, 5.
- Heat, light, supplies, telephones, water, short-lived office equipment, annual depreciation on furnishings and fixtures.

Office rental, 6.

Postgraduate studies, 9.

Professional dues, 7.
- American Medical Association.
- County Medical Society.
- State Medical Society.
- Special societies as:
  - American College of Surgeons.
  - American College of Radiology.
- Any other paid in interest of profession.

Salaries, 10.

Scientific meetings, 9.

Sales of spectacles, 11(e).

Taxes and licenses, 8.
- Alcohol license.
- Automobile license.
- Gasoline and oil taxes.
- Narcotic tax.
- Occupational tax.
- Property (real and personal)
- Professional equipment and material taxes.
- Reregistration fees.
- Social security taxes.
- State income tax.
- State unemployment compensation tax.

Theft of professional equipment, 11(d).

Traveling expenses, 9.
- Both professional calls and scientific meetings.

Wages and salaries, 1, 10, 11(c).
- Clerk, 10.
- Driver, 1.
- Laboratory assistant, 10, 11(c).
- Maid, 10.
- Nurse, 10.
- Physician, 10.
- Stenographer, 10.
- Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 10.

Explanation of Deductions

1. **Automobiles.** The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, driver's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, *while on professional calls,* are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be five years, 20 per cent depreciation based on cost price may be taken annually for five years. What has been said with respect to automobiles applies to other motive equipment.

The "cost price" for an automobile, or other business property, acquired on a trade-in of a similar asset is the depreciated cost of the old asset plus the boot money paid.

Example: Mr. Green bought a car in July 1951, for $500 cash, which was traded in July 1953, for a new one. It was used 50 per cent in business and depreciated at the rate of 20 per cent. Fifty per cent of two years' depreciation is $100. Its depreciated cost is therefore $400. One thousand dollars was paid to boot for the new car. The "cost price" of the new car is therefore $1,400.

2. **Bad Debts.** If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not deduct from income any unpaid debts because such items were never included in reported income.

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, and income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report.

3. **Library.** Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly, annual depreciation of 10 per cent of the cost of such library may be deducted.

4. **Medical Supplies and Instruments.** Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, *as may equipment, the life of which is less than one year.*

The average useful life of surgical instruments and equipment generally is now estimated at ten years, which means that 10 per cent of the cost may be taken as reasonable annual depreciation. X-ray equipment may ordinarily be depreciated at 10 per cent of cost.

5. **Office Expense.** General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable *average* depreciation rate for office equipment, furnishings and fixtures. Specific items may be higher or lower than this rate. Thus, a typewriter which, it was estimated, would last only five years would warrant a 20 per cent annual rate; while metal filing cabinets, with an estimated useful life of twenty-five years, would justify only a 4 per cent annual rate.

Where the space used for the conduct of a professional practice, including waiting rooms, examination rooms and laboratory, is owned by the taxpayer physican, or by a partnership of physicians, a reasonable depreciation may be taken annually on such building, based on its cost and life expectancy. If only a portion of a building is used for professional purposes, depreciation may be taken only on such portion.

6. **Office Rent.** If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house.

7. **Professional Dues and Subscriptions.** Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible as expenses.

8. **Taxes and Licenses.** Taxes paid upon materials required in professional work are deductible. All licenses which the physician is required to take out may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occupational and reregistration taxes. State taxes on gasoline and motor oil, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under the Social Security Act are also deductible. The social security tax deducted from the income of a salaried physician is not deductible by him, however.

The physician may also deduct all real estate and personal property taxes paid by him, even though the property taxed is not used for professional purposes. This would include, for example, taxes on a vacant lot or on a launch.

Nonbusiness taxes paid during the tax year by one on a cash basis are generally deductible, except for: Federal income tax; federal estate and state inheritance taxes; federal or state gift taxes; federal excise taxes, such as those of theater tickets, jewelry, furs, silverware, transportation, cigarettes, telephone, and the like. Also non-deductible are: the employee's share of federal old age insurance tax;

federal transfer taxes on corporate securities or real estate; state or local property assessments for improvements; and state and local taxes on tobacco and cigarettes which are not imposed on the consumer (including Wisconsin). Excise taxes on transportation and communications are deductible if paid in connection with business expenses. Transfer taxes on corporate securities and real estate are not deductible as such, but the amount thereof may be used to reduce the selling price, which has the effect of allowing them as expenses. However, such taxes relating to property used in business are deductible from adjusted gross income, as explained above, while nonbusiness deductible taxes must be listed on page 3 of the return.

9. Traveling Expenses. Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending postgraduate medical courses are now deductible. See page 642 of this article, first column, under the heading, "1953 Court Decisions."

10. Wages and Salaries. Deductions are permitted for the salary of a physician, nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employees for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. Miscellaneous. (a) Legal Expenses.—Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessments or refunds, are deductible, but legal fees paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment may be included any automobile belonging to the physician and used partially or wholly for professional purposes.

(c) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) Losses by Fire, Theft, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable,* may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction.

Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft, storm, or other casualty *where not compensated for by insurance or otherwise.* Examples of this type of casualty would include damage to trees and shrubs caused by storm or flood; damage to floors and furnishings caused by bursting water pipes; injury to boats or launches caused by storms; damage to a car, whether caused by the physician's negligence or that of someone else.

To repeat, such items as those above indicated *cannot* be deducted where, or to the extent that, the taxpayer is compensated for such loss by insurance settlements, law suits, or sums paid over without law suits by a person or persons causing the damage.

Special relief is also given to persons who have suffered heavy casualty losses; for example, an individual whose property has been destroyed by flood. In effect, the measure allows taxpayers who have a taxable loss, rather than a taxable income, occasioned by a casualty loss, to carry this loss back one year and forward five years so as to offset income in the preceding year or the five succeeding years.

(e) Sale of Spectacles—Oculists who furnish spectacles, etc., must enter as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

(f) Medical Expenses. Medical, dental, drug, nursing, hospital, and related expenses, including fees for services rendered by other physicians, *which are in excess of* 5 per cent of the taxpayer's adjusted gross income, may be deducted if *actually paid* during a given year. The provision "which are in excess of 5 per cent of the taxpayer's adjusted gross income" does not apply to the situation where *either* the taxpayer *or* his spouse is over 65 years of age, although it does apply to their dependents. The cost of hospitalization and surgical insurance may, except as provided below, be included in such deduction, as may travel where directly related to hospitalization or recuperation, and the travel expenses of a minor child and parent, which are directly related to hospitalization and medical care. The

taxpayer cannot claim a deduction for travel for general health, unrelated to a specific condition requiring change of climate, or for general health travel combined with vacation.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $17.

To the extent that any health expenses are compensated for by insurance or otherwise, they are not to be included. For example, if the annual cost of a hospital and surgical benefit policy during 1953 was $72, and $60 in benefits was received from such policy during the year, only the difference between the cost and the benefits, or $12, could be shown as the net cost of this medical expense item for 1953. If more than $72 was received in benefits during the year, *none* of the premium cost is deductible as medical expense, since the taxpayer received in benefits more than he spent as premium. Where the cost of health insurance has been deducted in one tax year and its cash benefits are not received until a subsequent year, such benefits must be deducted from the premium costs in such latter year. If the benefits received in such latter year exceed the premium cost for that year, the excess of benefits over the total premium must be included in the gross income for such year.

The maximum deduction for medical expenses on a separate return for one exemption is $1,250, and for two or more exemptions is $2,500. The maximum deduction in the case of a joint return by husband and wife is $2,500 where there are no other exemptions, as for dependents. This amount is increased to $3,750 where there is a dependent in addition to husband and wife, and to $5,000 where there are two or more dependents in addition to a husband and wife who make a joint return. The maximum allowances are summarized in the following table:

Joint Return	Maximum Allowable
Husband and wife	$2,500
Husband and wife and one other exemption	3,750
Husband and wife and two or more other exemptions	5,000
Separate Return	
One exemption	$1,250
Two or more exemptions	2,500

Situations may arise where, by reason of the rule limiting medical expenses to the excess over 5 per cent of adjusted gross incomes of husband and wife, a joint return will decrease the medical deduction in some cases. This will seldom occur, however.

The expense must be for the medical care of the taxpayer, his spouse, or a dependent. Taxpayers are required to furnish the name and address of each person to whom such expenses were paid, and the amount and approximate date of payment. Where a joint return is filed, the 5 per cent limitation is computed on the aggregate adjusted gross income of husband and wife. Payments for waiver of premiums on a life insurance policy are *not* includable as medical expense.

Example: Assume the taxpayer has a gross income of $10,000 and that the total of the medical, dental, hospitalization and related expenses paid in a given year for himself and his family was $1,500. Since there is no recognition given to such expenses up to the point where they equal 5 per cent of his adjusted gross income, the first $500 of his expenses are not deductible. He would, therefore, be allowed to deduct only the remainder, or $1,000.

(g) Interest Paid. With the two exceptions noted in this paragraph, all interest paid by a physician is deductible for federal tax purposes, even though it may have been for a non-professional indebtedness, such as the purchase of a home. The two exceptions are: (1) Interest paid on an indebtedness incurred to purchase or continue ownership of securities, the interest on which is wholly tax exempt; and (2) Interest paid on an indebtedness permitting the purchase of a single-premium life insurance or endowment contract. An insurance purchase is considered on a "single-premium" basis if substantially all payments are made within four years from the date of original purchase of such contract.

If a husband pays interest on an indebtedness of his wife, he cannot claim it on his individual return, and she may not claim it on hers, because it was not paid by her. It could be taken on a joint return, however.

11. STATE OF WISCONSIN

Introductory

The 1953 Wisconsin legislature made sweeping changes in the Wisconsin income tax law, effective for taxes payable on income for the calendar year 1953, or a corresponding fiscal year, and for years thereafter. The following text incorporates the 1953 legislative changes into the earlier income tax law of Wisconsin.

General Instructions

Returns of 1953 state income must be made to the assessor of incomes of the district in which the taxpayer resides on or before March 15, 1954. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the assessor of the department of taxation for the district in which the taxpayer lives. Such extension

must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Income Tax Returns

No Joint Returns. Joint returns by husband and wife are *not* allowed under the new Wisconsin law. Formerly, Wisconsin *did* allow the joint returns by husband and wife if the optional "short form" return was filed. Under the new law, a wife having an income separate from that of her husband must file her own return.

Liability to Make Tax Return. Every resident must file a return, whether notified to do so or not, if:

(1) He is single, and his gross income is $600 or more.

(2) He is a married person receiving *any* net income during the year when the combined net incomes of such person and his or her spouse is $1,400 or more. In other words, a wife having $300 of net income will be required to file a separate return even though her gross income is less than $600, provided her husband has at least $1,100 of net income.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. When a person changes his permanent residence to or from Wisconsin during the year, liability to taxation for income which follows residence shall be determined on the basis of the income received during the part of the year such person was a Wisconsin resident. Personal exemptions are prorated on the basis of time of residence within and without the state.

Optional Returns. An optional "short form" return may be filed. The return is similar to the federal "short form" return. It may be used only if *all* the following conditions are met.

(1) *Adjusted gross income* must be less than $5,000.

(2) The taxable year may not, by reason of a change in the accounting period, cover less than twelve months.

(3) If the taxpayer is married and his spouse is required to file a return, the spouse must have elected to file the optional "short form" return or have claimed the optional standard deduction on the long form.

(4) The taxpayer must not have moved into or out of the state within the year.

Elimination of 2% Cash Discount

The new law eliminates the former 2% cash discount allowed if the tax was paid in full on or before March 15 of the year following the taxable year.

Instead, the new law requires payment of at least one third of the total tax, but not less than $20, by March 15. The balance may be deferred until not later than August 1, and to this amount an additional 2% of such amount must be added.

Minors

Minors, regardless of age, or their guardians, whether natural or appointed, must file a return reporting all income if they fall within the classifications set forth in this article on this page, under the subheading, "Liability to Make Tax Return."

Unlike previous Wisconsin tax laws, which required the earned income of children 18 years of age or under to be added to that of the father or head of the family, the new Wisconsin statute treats a minor as a separate taxpayer, subject to the legal requirements as to filing of returns and payment of taxes.

The personal exemption allowable to the minor or guardian shall be the same as that allowable to any other person.

Where the gross income of the minor for the calendar year is $600 or more, the parent is not allowed to consider the child a dependent.

Liability for the tax on income of a minor child is placed on the parent if not paid by the child.

Adjusted Gross Income

The term "adjusted gross income," as used in the new Wisconsin income tax law, means the sum of all items of income, except that part specifically exempt from Wisconsin income taxation, minus all deductions allowed by the Wisconsin income tax law, except the following deductions:

(1) Income taxes imposed by the State of Wisconsin or by the United States government.

(2) Medical expenses.

(3) Interest paid, other than that paid on indebtedness incurred to carry on a profession or business from which taxable income is derived.

(4) Contributions.

(5) Alimony payments.

(6) Amounts expended for forest crop lands planting.

(7) Dues to unions or professional societies.

Capital Gains and Losses

Full gains or full losses are recognized, irrespective of the length of time the asset was held. However, gains on real estate sales other than nonrecognized gains on sales of residences, may be reported on the installment basis provided *not less* than 30% of the sales price is received during the first contract year.

Gain or Loss on Sale of Residence

The new Wisconsin income tax law has adopted the recently enacted federal rule pertaining to the sale or exchange of property used by a taxpayer as

his personal residence. The federal rule is set forth generally at page 648 of this article.

For Wisconsin income tax purposes, the rule pertaining to sale or exchange of residence becomes applicable to sales of old residences made in an income year ending on or after July 31, 1953. *The statute has left unanswered the exact date when a transaction becomes a "sale" for purposes of applying the new residence rule. For example, does a calendar year taxpayer subject himself to reportable income if he accepts an offer to purchase in December of 1952, but does not close the deal until January of 1953.*

Armed Forces Income

The first $1,500 of compensation received by a person on active service, or as a reserve member of the United States armed forces for the years 1953 and 1954 is exempt.

For the years 1953 and 1954, if a taxpayer is on active service with the United States armed forces and is beyond the borders of the United States on the first day following the close of his income year, or on the 15th day of the third month following the close of such year, the time for filing a return is postponed to a period ending within six months following the termination of such active service, but in no event later than the 15th day of the sixth month following the close of the 1954 calendar year or corresponding fiscal year.

Annuity Rule

As distinguished from the federal rule governing annuity income, the Wisconsin rule provides that annuity payments under an endowment or annuity contract are income to the extent of any payment *after* the income tax cost (aggregate premiums or consideration) has been recovered. However, when the contract provides for the separation of the periodic payment into principal and interest, the interest so received is taxable when received.

Income Tax Rates

The teachers' retirement surtax has been eliminated as a separate computation on the income tax return. It has been incorporated into the new rates created by the 1953 legislature, which approximate in one computation the amount of tax which formerly required 2 computations. The new rates are as follows:

Income Bracket	*New Rate*	*Income Bracket*	*New Rate*
1st $1,000	1.00%	9th $1,000	5.50%
2nd $1,000	1.25%	10th $1,000	6.00%
3rd $1,000	1.50%	11th $1,000	6.50%
4th $1,000	2.50%	12th $1,000	7.00%
5th $1,000	3.00%	13th $1,000	7.50%
6th $1,000	3.50%	14th $1,000	8.00%
7th $1,000	4.00%	Over $14,000	8.50%
8th $1,000	5.00%		

Exempt Income

The following income is exempt from Wisconsin income taxation:

(1) Pensions received from the United States.
(2) All inheritances, devises, bequests, and gifts received during the year.
(3) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society, or other insurer, *including* insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners, or employees.
(4) Interest on obligations of United States; postal savings interest is taxable, however.

Personal Exemptions

After the tax has been computed, personal exemptions are deducted in arriving at the net tax payable. A $7 exemption is allowed for the taxpayer, an additional $7 for the spouse, and an additional $7 for each dependent whose gross income is less than $600.

An additional $7 is allowed a "head of a family," who is defined to mean an unmarried taxpayer who maintained a household and supported therein a dependent as well as himself. For example, a widower maintaining a household in which he supported his three-year-old son would be entitled to total exemptions of $21.

Dependents. The age of the dependent or his ability to support himself is not material. A dependent means one of the following persons, over half of whose support for the calendar year was received from the taxpayer, and whose income was less than $600:

1. A son or daughter of the taxpayer, or a descendant of either.
2. A stepson or stepdaughter of the taxpayer.
3. A brother, sister, stepbrother, or stepsister of the taxpayer.
4. The father or mother of the taxpayer, or an ancestor of either.
5. A stepfather or stepmother of the taxpayer.
6. A son or daughter of a brother or sister of the taxpayer.
7. A brother or sister of the father or mother of the taxpayer.

"Brother" and "sister" include a brother or sister by the half-blood. A legally adopted child is considered a child by blood.

A taxpayer who was married during the year and claims an exemption for his wife is entitled to a full exemption for her during that year, if at the close of his taxable year he was still married to such spouse, or, if she died during the taxable year, he was married to her on the date of her death.

The fact that a dependent was not in existence throughout the year is immaterial. Thus, if a child

of the taxpayer is born or dies during the taxable year, a full exemption is allowable for such child. The dependent must, however, be a resident of Wisconsin.

The deductions for personal exemptions must be prorated on the basis of the time of residence within and without the state in the case of those taxpayers or their dependents who move into or out of the state within the taxable year.

Deductions

The 1953 Wisconsin income tax act revision left untouched most of the old law pertaining to deductions. The changes which were made by the 1953 legislature are discussed below.

A. 1953 Changes

Optional Standard Deduction. The old income tax law provided that in lieu of itemizing deductions on page 2 of the Wisconsin income tax return, the taxpayer could elect to deduct an "optional standard deduction" equal to 9% of gross income, but in no case to exceed $450. The new law allows an "optional standard deduction" only in cases where the gross income of the taxpayer is $5,000 or more. The new law provides that the amount of the optional standard deduction shall be $450.

The new law contemplates that in cases where the gross income is under $5,000, the short form of tax return is to be used in cases where the deductions are not itemized.

In cases where both the husband and wife are required to file tax returns, both must itemize deductions, or both must use either the optional standard deduction or file their returns on the short form.

Medical Expenses. The language of the statute allowing medical expenses has been substantially reworded. Its essence, however, has been changed in only two respects. In the first place, the old law provisions permitting deductibility of all medical expenses in excess of $50, but not exceeding $500 of such expense, has been changed by the new law to allow the deduction of the excess over $75, but not exceeding $1,500. In effect, the new law gives greater benefit to the taxpayers incurring sizeable medical expenses with but slight penalty against the taxpayers having small disbursements.

In the second place, premiums paid for health and accident insurance are specifically made deductible by the new law. Previously the statute was silent on this point.

Traveling and Entertainment Expenses. The new law makes specific the deductibility of traveling expenses, including the entire amount expended for meals and lodging while away from home in the pursuit of a profession, trade, or business. The new statute also allows deduction of reasonable expenses *for the entertainment of clients, patients, or customers,* and the unreimbursed expenses for food, travel, or lodging incurred by an employee when required to be away from home in the performance of his job. It should be noted that the statute allows entertainment of "clients, patients, or customers."

The above language should eliminate most of the problems encountered by professional people in past years regarding deductibility of such expenses. Whether the statute is broad enough to allow deductibility of entertainment expenses of specialists who entertain general practitioners referring clients to them remains to be seen. The Wisconsin Board of Tax Appeals had previously held that such entertainment expenses were not deductible by a physician specialist, whose practice was made up almost entirely of referrals from general practitioners.

Likewise, whether the language of the new statute is broad enough to allow deductibility of golf club dues and dues of similar organizations remains to be seen. Here, too, the Board of Tax Appeals had ruled, under the old law, that the social aspects of such "expenses" were too closely interwoven to allow deduction as ordinary and necessary business expenses.

Expenses Incurred in the Earning of Salaries. Taxpayers who incur deductible expenses in the earning of wages, salaries, fees, and commissions may deduct these expenses from their gross salaries, wages, fees, and commissions and also elect to take either the optional standard deduction or use the optional tax table on the short form return. Unlike the federal rule which allows employees to deduct "business expenses" in addition to the standard deduction only if they fall within the term "traveling expenses" or are reimbursed expenses, Wisconsin allows any deductible expenses in addition to the optional standard deduction, provided they are incurred in the earning of the salaries, wages, etc.

Both the gross amount of the compensation and the total of such expenses should be shown at the line provided on the return for the reporting of salaries and wages, and only the net amount shall be extended into the money column.

B. Statutory Deductions

The statute setting forth what constitutes allowable deductions of major items of expense is so clear that portions of it are reprinted here as an aid to physicians in making state returns:

Section 71.05.

(1) Payments made within the year for wages or other compensation, if reasonable in amount, for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deductions shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of $700 or more shall have been paid for services during the assessment year. Except as provided in subsection (9) of this section, no deduction shall be allowed under

this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, trade or business from which the income is derived, including traveling expenses (including the entire amount expended for meals and lodging while away from home) in the pursuit of a profession, trade or business, and including also a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived, and in the case of mines and quarries an allowance for depletion of ores and other natural deposits on the basis of their actual original cost in cash or the equivalent of cash. Provided, however, that no deduction shall be allowed for rent paid unless the payer reports the amount so paid together with the names and addresses of the parties to whom rent was paid. The term "profession, trade or business" shall include the performance of the functions of a public office. The term "ordinary and necessary expenses" shall include reasonable expenses for the entertainment of clients, patients or customers and the unreimbursed expenses for food, travel and lodging incurred by any employee of an employer when required to be away from home in the performance of his job.

(3) Interest paid within the year on existing indebtedness; provided the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(4) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the state of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(4a) The deduction for all United States income, excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of the deduction of said United States income, excess or war profits and defense taxes, and before the deductions of amounts permitted by subsection (6) of this section. In no event shall any taxpayer be permitted hereunder a total deduction in excess of the actual amount of United States income, excess or war profits and defense taxes paid, and otherwise deductible.

(6) Contributions or gifts made within the year to any corporation or association organized and operated exclusively for religious purposes, to any national organization of veterans of the armed forces of the United States or subordinate unit thereof, or to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation or association operating within this state, organized and operated exclusively for charitable, scientific or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of 10 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

(7) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

(8) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located within the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition. Reserves for contingent losses or liabilities shall not be deducted.

(9) With respect to determination of net taxable income for the calendar year 1953 and corresponding fiscal years, and thereafter, expenses paid during the income year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or of a dependent specified in Section 71.09 (6) (b) (regardless of the gross income of such dependent) in excess of $75 but not more than $1,500. Expenses paid for medical care under this subsection, shall include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance).

(10) Any and all sums not to exceed $800 paid by any person by way of alimony to a former spouse under any order or decree of any court.

C. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Driver, 1.
  Insurance, 1, 3.
  Maintenance.
  Professional use.
  Repairs.
Bad debts, 2.
Bandages, 8.
Conventions, 7.
Contributions and gifts, 15 (f).
Depreciation.
  Automobiles—20 per cent annually of cost price, 1.
  Instruments, 8.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on x-ray equipment.
  Medical library, 5.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dues, 11.
Entertainment Expenses, 16.
Equipment. Rate must be reasonable.
  Office, 9.
  Professional, 8, 15 (a).
Fire, loss by, 6.
Instruments, 8.
Insurance premiums, 3.
  Automobile, 1.
  Hospital and surgical, 15 (g).
  Malpractice, 3.
  Professional equipment, 3.
Interest paid, 4.
Laboratory materials, 8, 15 (a).
Legal expenses, 15 (b), 15 (d).
Library, 5.
Licenses, 12.
Losses, by fire, flood, theft, suit, etc., 6, 15 (d).
Medical convention, 7.
Medical expense, 15 (g).
Medical Society group health and accident annual premium, deduct $17. See 15 (g).
Medical supplies, 8.
Miscellaneous, 15.
Office expenses, 9.
  Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 10.
Postgraduate studies, 13.
Professional conventions, 7.
Professional dues, 11.
  American Medical Association.
  County Society.
  State Society.
  Special societies as:
    American College of Surgeons.
    American College of Radiology.
  Any other paid in interest of profession.
Professional subscriptions, 5, 11.
Salaries, 14.
Sale of spectacles, 15 (c).
Scientific meetings, 13.
Subscriptions, 5.
Taxes and licenses, 12.
  Automobile licenses.
  Federal income—3 per cent maximum.
  Import duties, etc.
  Personal property taxes.
  Professional license fees.
  Real property taxes on office owned and used by taxpayer in practice.
  Social security taxes.
  Wisconsin income taxes and surtaxes paid.
  Wisconsin unemployment taxes.
Theft, loss by, 6.
Traveling expenses, 7, 13.
  Both professional calls and scientific meetings.
Wages and salaries, 14.
  Clerk, 14.
  Driver, 1.
  Laboratory assistant, and technicians, 14, 15 (a).
  Maid, 14.
  Nurse, 14.
  Stenographer, 14.
  Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 14.

D. Explanation of Deductions

In numerous instances below, references are made to numbered paragraphs of the federal portions of this tax summary. These will be found on pages 651 to 653 of this article. Where the text on federal taxes is equally applicable to Wisconsin returns, reference is made to the former so as to avoid needless repetition. Where the explanation applicable to Wisconsin income taxes varies from the federal, such explanation is separately given in the paragraphs following.

1. **Automobiles.** (See paragraph 1, page 651).

For Wisconsin income tax purposes, the cost price for an automobile, or other business property, acquired on a trade-in of a similar asset is the list price of the asset, regardless of whether it was an outright purchase or a trade-in deal. The Wisconsin rule is in this respect different from the federal rule.

2. **Bad debts.** (See paragraph 2, page 651).

3. **Insurance Premiums.** Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged mal-

practice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used partially or wholly for professional purposes.

4. Interest Paid. Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of income producing property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

5. Library. A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

6. Losses by fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

7. Medical Conventions. Ordinary and necessary expenses incurred in attending medical conventions or professional scientific societies, necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

8. Medical Supplies and Instruments (See paragraph 4, p. 651.)

9. Office Expenses (See paragraph 5, p. 651.)

10. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

11. Professional Dues and Subscriptions (See paragraph 7, p. 651).

12. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.

(b) Personal property taxes paid on his apparatus and equipment.

(c) Wisconsin income taxes and surtaxes paid.

(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum

deduction not to exceed 3 per cent of net income computed under the state law *before* contributions.

(e) All license fees incident to his profession.

(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.

(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.

(h) All social security taxes paid by the physician in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. A salaried physician is required to include the amount of the social security tax paid by him in determining his gross salary. He is then permitted by the same rule to deduct the amount of the social security tax withheld from him and to include it as part of his federal income tax, subject to the 3 per cent maximum rule noted in subhead (d) above.

Taxes which are not deductible include: Real estate on residence property occupied by the owner; automobile license fee, gasoline, cigarette and amusement taxes, inheritance taxes, special assessment taxes; and taxes on vacant lots. However, doctors, traveling salesmen and others who use their automobiles in the production of their income may include the gas tax, and auto license fee as a part of the cost of operating the automobile.

13. **Traveling Expenses** (See paragraph 9, page 652).

14. **Wages and Salaries** (See paragraph 10, page 652 and 15 (e) below.

15. Miscellaneous.

(a) Laboratory Expenses (See paragraph 11 (c), page 652).

(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expenses. Expenses incurred in the defense of a criminal action, however, are not deductible.

Legal expenses incurred in connection with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.

(c) Sales of Spectacles (See paragraph 11 (e), p. 652).

(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an office and organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

(f) Contributions or gifts made to public, religious, educational, charitable, veteran's, or other groups listed in section 71.05 (6), Wisconsin Statutes, 1953, quoted on page 657 of this article are deductible to an amount not in excess of ten per cent of the taxpayer's net income for the fiscal or calendar year.

(g) Medical expenses—payments in excess of $75 but not over $1,500 for hospital, nursing, medical, surgical, dental services and medical supplies incurred by the taxpayer on account of illness or of personal injury to himself or his dependents.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment. are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $17.

16. Entertainment Expenses. As noted in this article at page 656, under the heading "Traveling and Entertainment Expenses," the 1953 law allows deduction of reasonable expenses for the entertainment of clients, patients, and customers. Careful records of any such expenses should be maintained.

Importance of Adequate Accounting Records

It is equally true under both the federal and the Wisconsin laws that a properly maintained set of double-entry accounts is probably the greatest single means of facilitating the preparation of a physician's income tax returns, and of enabling him to secure the maximum advantage from the exemption and deduction statutes. Such a bookkeeping system is neither complicated nor unreasonably time consuming. It can be installed by any competent accountant at a reasonable cost, and can be maintained by any trained bookkeeper. A large number of tax complications would never arise if adequate accounting records were available to serve as the basis of tax returns, or as the authority for settling questions at an early stage.

UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

February 1–5: "Child Psychiatry for General Physicians, Pediatricians, and Psychiatrists"

Consisting principally of small group discussions of common problems rather than didactic lecture material, the course will be presented under the direction of Reynold A. Jensen, professor of psychiatry and pediatrics at Minnesota. The guest faculty will include Sherman Little, M. D., Buffalo (N. Y.) Children's Hospital; Mabel Ross, M. D., U. S. Public Health Service; and Henry H. Work, University of Louisville Medical School.

February 10–11: "Cancer Detection for General Physicians"

This two-day course is presented under the joint auspices of the University of Minnesota and the Minnesota Division of the American Cancer Society. Registrants will observe and participate in the diagnostic activities at the University's Cancer Detection Center and are invited to attend the dedication program of the medical school's new cancer research unit, the Lyon Laboratories.

February 15–16: "Fundamental Advances in Internal Medicine for Internists"

Basic concepts in the fields of infectious disease, gastroenterology, and hematology will be discussed. Cecil J. Watson, M. D., professor and head of the department of medicine, and other members of University of Minnesota Medical School will present the course with the assistance of Walter Lincoln Palmer, M. D., of the University of Chicago School of Medicine and David Shemin, M. D., of Columbia University College of Physicians and Surgeons.

February 18–20: "Infertility Problem"

This course is designed to meet the needs of physicians frequently consulted by infertile couples. Dr. Alan F. Guttmacher, Director of the Department of Obstetrics and Gynecology, Mount Sinai Hospital, New York City, will be the guest speaker.

Medical and gynecologic procedures in diagnosis and management of sterility problems will be stressed, and fertility control and genetic aspects of infertility will be considered. Also scheduled is a panel discussion on the subject of adoption procedures.

TABLE OF CONTENTS

Transactions of the 1953 Regular Session, House of Delegates, State Medical Society of Wisconsin

Page

First Session, Monday, October 5, 1953 663
- Report of the Speaker 663
- Announcement of Reference Committees 663
- Minutes of the 1952 Session Approved 663
- Report of Committee on Credentials 663
- Standing Rules Adopted 664
- Reports of Officers 664
  - Report of the Council 664–696
    - Report on Necrology 666
    - The Commission on Prepaid Plans 667
    - The Commission on State Departments 678
    - Committee on Blood Banks 690
    - Veterans Agency Operating Committee 691
  - Supplementary Report of the Council 692
    - Committee on Civil Defense 692
    - Committee on Military Medical Service 694
    - Student A.M.A. 695
    - Special Report on the Bricker Resolution 695
  - Report of the President 696
  - Report of the President-Elect 697
  - Report of the Treasurer 698
  - State Selective Service Representatives Introduced 700
  - Report of the Secretary 700
- Introduction of Guests 702
- Excerpts from Address of the President of the Woman's Auxiliary 702
- Excerpts from Remarks of State Health Officer 711
- Excerpts from Supplementary Report of Division on Maternal and Child Welfare 712
- Excerpts from Supplementary Report of Council on Medical Service 712
- Reference of Reports 713
- Committee on Nominations Selected 713
- Adjournment 714

Second Session, Tuesday, October 6, 1953 714
- Report of Committee on Credentials 714
- Report of Reference Committees 714
  - Report of Reference Committee on Reports of Officers 714
    - Report of the President 714
    - Report of the President-Elect 714
    - Report of the Speaker 714
    - Report of the Treasurer 714
    - Report of the A.M.A. Delegates 714
    - Report of the Woman's Auxiliary 715
    - Report of the Secretary 715
    - Report of the Committee on Civil Defense 715
    - Report of the Committee on Military Medical Service 715
    - Report on the Student A.M.A. 715
- Introduction of Guests 715
  - Report of the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws 715
    - Resolution on Section on Medical History 716
    - Resolution to Eliminate Citizenship as a Requirement for Membership 716
    - Resolution on License Revocation and Membership Status 716
    - Resolution Abolishing Time Limit for Speakers 716
    - Resolution to Provide for Educational Memberships 717
    - Report on the Bricker Resolution 717
    - General Report of the Council 717
    - Report of the Commission on Prepaid Plans 717
    - Report on Section Delegate Representation 717
    - Report of the Veterans Medical Service Agency 718
    - Dues for 1954 718
    - Informational Report to the Members 718
    - Further Action on Bricker Resolution 719
  - Report of Reference Committee on Reports of Standing Committees 719
    - Committee on Cancer 719
    - Committee on Grievances 721
    - Committee on Hospital Relations 724
    - Committee on Medical Education and Hospitals 724
    - Council on Medical Service 726
    - "March of Medicine" Radio Program 731
    - Committee on Public Policy 732
    - The Commission on State Departments 735
    - Council on Scientific Work 735

Third Session, Wednesday, October 7, 1953 737
- Report of the Committee on Credentials 737
- Report of Committee on Nominations 737
- Election of Councilors 737
- Acceptance of the President-Elect 738
- Appreciation Expressed to Doctor Kidder 738
- New Speaker and Vice-Speaker Presented 738
- The Bricker Resolution 738
  - Excerpts from Presentation by Mr. Robert B. Murphy 739
  - Excerpts from Presentation by Mr. Joseph Stetler 740
  - Recommendation of the Council 741
  - Opposition's Arguments 741
  - Question and Answer Period 742
  - Action on Council Recommendation 742
- Introduction of Doctor Campbell 742
- Appointments to Grievance Committee 742
- Exhibit on Medicine in Art 742
- Retiring Officers Thanked 742
- Adjournment Sine Die 742

Transactions of the 1953 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Monday, October 5, 1953

The opening session of the House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, convened at 9:50 a.m., Dr. G. E. Forkin, Speaker of the House, presiding. A moment of silent prayer was observed.

Report of the Speaker

Doctor Forkin presented the following remarks:

"As you are well aware, for more than 100 years this House of Delegates has been meeting in annual session to carry to the state level the thoughts of our various county society districts, problems that may need organized medicine. You men are here as representatives of your own counties, and you have been selected because of certain qualifications that you possess.

"First of all, you have the confidence of the men who know you best; you are men who have made a success of the practice of medicine; your ethics have always been beyond criticism; you have been known in your communities as men who are eminently fair, both to your fellow practitioners and to your patients.

"You come here with certain ideas that have been transmitted to you in the past by your members in the county, and we trust you are going to give expression to some of those thoughts here. This organization, as you know, has been founded on democratic principles, so democratic in its organization that there is no reason for ever having the criticism made that things are rushed through here without adequate consideration. We ask that everybody enter into a discussion of any problems that come up. We ask that questions be asked about things that may not be clear to you.

"The House of Delegates has been composed in the past of the big men in our Society. Any man in a community who stands out above his fellow men has served in the position you are now occupying. The chairs you are filling today have been filled by the biggest men in our state. To cite a few of these names invites criticism, but I think if we go back over the history of this Society and see who built its foundation, it would be interesting.

"I could begin the citation of men by first naming Nicholas Senn. Over the years we have had Doctor Ground of Superior; Doctor Dodd of Ashland; and for many years we had Doctor Redelings of Marinette. We have had the Jacksons at Madison; we have had Bardeen of Madison; we have had Jobse of Milwaukee; we have had Connell of Oshkosh. I could go on and name 30 to 40 men who have given of their time and their money to come here and work for this wonderful state organization.

"In recent years I think there has been little of the close contact we have enjoyed in the State Society in liaison between the county and state. Some of that has been lost. The work of the state organization has gone on smoothly, and the apathy that has developed among the membership in our county societies, I think, is partly the fault of our own state organization.

"I have one suggestion to make—that immediately following this meeting, each delegate ask his county program chairman to allot one meeting for a report as to what he has encountered at this meeting. The December issue of the *Wisconsin Medical Journal* will carry a complete report on what has been accomplished here, but that is an official report. We can do a whole lot more to overcome any criticism and lack of understanding in our counties by a direct personal report, in which things that are not included in the *Journal* may be discussed."

Announcement of Reference Committees

Speaker Forkin announced the following appointments to Reference Committees:

Reference Committee on Reports of Officers: L. O. Simenstad, Osceola, chairman; S. A. Morton, Milwaukee; W. D. Stovall, Jr., Brodhead; R. H. Bitter, Oshkosh; and L. M. Lundmark, Ladysmith.

Reference Committee on Reports of Standing Committees: G. W. Carlson, Appleton, chairman; N. A. Eidsmoe, Rice Lake; C. W. Stoops, Jr., Madison; C. A. H. Fortier, Milwaukee; and Charles W. Giesen, Superior.

Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: H. E. Kasten, Beloit, chairman; T. W. Tormey, Jr., Madison; S. W. Hollenbeck, Milwaukee; S. D. Beebe, Sparta; and J. D. Leahy, Park Falls.

Minutes of the 1952 Session Approved

On motion of Dr. T. W. Tormey, Jr., Madison, seconded by Dr. E. C. Cary, Reedsville, carried, minutes of the 1952 regular session of the House of Delegates, as printed in the December 1952 issue of the *Wisconsin Medical Journal*, were approved.

Report of Committee on Credentials

The Committee on Credentials, composed of Drs. T. J. Aylward, Milwaukee, chairman; E. W. Humke, Chilton; and M. V. Overman, Neillsville, verified the registration of 61 delegates and seven alternate

delegates entitled to vote at this session of the House of Delegates. In addition, 15 alternate delegates and two past-presidents registered their attendance.

On motion of Doctor Aylward, seconded by Dr. E. D. Sorenson, Elkhorn, carried, the attendance roll totalling 68 was accepted as the official roll of this session of the House, to stand for the entire session.

Standing Rules Adopted

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. H. E. Kasten, Beloit, carried, the following standing rules, as adopted in previous sessions, were approved for this session:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.

Reports of Officers

The following report of the Council was published in the Delegates Handbook:

REPORT OF THE COUNCIL

R. G. Arveson, chairman

It has long been the practice of the Council to direct the preparation and publication of its minutes in detail in the *Wisconsin Medical Journal*, but the increasing complexity of Society affairs necessitates a longer period for the preparation of these minutes. Consequently, there is delay in their publication. Yet, for the member of the Society, who wishes to follow actions of the Council closely, that opportunity is his.

It is not the purpose of the annual report of the Council to recapitulate its actions over the course of the year, but rather to high light those which seem of unusual consequence and to report those not yet printed in the *Journal*.

A number of resolutions are being offered by the Council for House action but are not made part of this report as they require individual consideration rather than consideration as part of an over-all report. They may be found on pages 25–29 of this Handbook.

State Offices

For more than a year the Council has been concerned with adequate space for the headquarters activity. At present, there are 60 full-time employees engaged in general activities of the Society, the *Wisconsin Medical Journal*, the Veterans Medical Service Agency, and the Blue Shield Plan, housed in the building purchased by the Society five years ago, when it was not anticipated that Blue Shield administrative activities would be moved into Madison. Present quarters, together with the garage space, provide less than 5,000 square feet of usable area and are entirely inadequate for present purposes of the Society.

Property has been acquired in Madison at a cost of $18,000, containing more than two acres situated in the southern part of the city on a site overlooking Lake Monona. Plans are proceeding for the erection of a building, costing in the neighborhood of $415,000, including architect and landscaping fees. It will be of sufficient size to accommodate 80 to 85 employees and will provide adequate space for the Society's technical equipment, such as the IBM machinery.

A realty corporation is in process of organization so that the building may be financed through mortgage loan, as well as by current assets of the Society.

While the building is urgently needed, the Council has decided that financing should be entirely within the Society's operations rather than include outside sources; and a period of time will be necessary to accumulate funds sufficient for that purpose. There will be no assessment or special dues levied against the membership, nor is an increase in the dues structure recommended.

Council Committees

By assignment of the House of Delegates, certain committee activities of the Society are carried on under Council direction, to assure that these committees continue to function and coordinate their respective efforts. Principal among these, of course, are the Commission on Prepaid Plans and the Commission on State Departments, reports of which follow the general report of the Council.

The councilors and officers appreciate the tremendous amount of time and effort members of these two Commissions and their respective committees have given to their responsibilities. There are nearly 100 physicians involved, and their services should receive the commendation of the House along with those of other committees which have so successfully followed the responsibility of the profession in economic and scientific medicine. These reports speak for themselves, and it is with considerable satisfaction that it may be stated that no change in any respect has been made by the Council itself.

The Wisconsin Medical Journal

During the May meeting of the Council a detailed review was made of the operation of the *Wisconsin Medical Journal*. Assisting the Council were Dr. R. S. Baldwin, the medical editor; and Dr. James M. Sullivan, the editorial director. There was a detailed review made of all phases of *Journal* operation, including medical editing, editorial direction, advertising policies, and financial and mechanical operations.

From an examination of the budget the membership will be aware that the *Journal* is operated at a loss, but in a sense this is a paper loss inasmuch as many expenses of the *Journal* are encountered by reason of the fact that it is the official publication of the State Medical Society and must carry such matters as the minutes of the House of Delegates, committees, and other material relating to the organizational affairs.

Furthermore, the *Journal* is provided the members of the senior class of the two medical schools without charge; and in addition, the annual Blue Book edition is made available to the junior students. This type of circulation has proved very helpful to students and is a service to them that could not otherwise be duplicated.

During 1954 the Blue Book, published in 1949, will be revised; and with the January *Journal* of 1955, it will be distributed to the entire membership. The Blue Book and the January issue, as a supplement, have proved invaluable to physicians throughout the state; and the Council is of the belief that this publication should be continued.

Resolution of Pathologists

In November, 1952, the Wisconsin Society of Pathologists submitted a resolution with regard to re-employment of physician members who are called into the armed forces. Council approval was given to it.

> WHEREAS, Under the provisions of Public Law 779, 81st Congress (Doctors' Draft Law), members of the Wisconsin Society of Pathologists and/or of the Section on Pathology of the State of Wisconsin Medical Society may be called to duty with the U. S. Armed Forces, and
>
> WHEREAS, These physicians may be associated with institutions under conditions in which the re-employment provisions of the Universal Military Training Act as governed by U. S. Code Title 50, Section 459 may not be operative, and
>
> WHEREAS, The loss of such association, by the physician upon return from Armed Forces service through the employment of a second physician by the institution during such period of service, would be unfair to the physician,
>
> NOW, THEREFORE, BE IT RESOLVED, That the members of the Wisconsin Society of Pathologists and/or the Section on Pathology of the State of Wisconsin Medical Society pledge jointly and to each other
>
> (1) To respect the temporarily vacant position of a fellow member on military leave of absence, and
>
> (2) To jointly provide such professional service as may be required by the institution during such period of absence;
>
> AND BE IT FURTHER RESOLVED, That this resolution be forwarded with a recommendation for parallel action to the organized radiologists and physiatrists in the State of Wisconsin and to the State of Wisconsin Medical Society for approval and publication.

Other Special Membership Services

As must be apparent to the House of Delegates, the Council is confronted with analysis and evaluation of all Society functions at the time it reviews and approves the annual budget of the Society. Prior to that, the Audit and Budget Committee, composed of five councilors, meets with the staff, the treasurer, and the accountants in preparation of material submitted to the Council. These two mechanisms, together with the fact that the entire activities of the Society are annually reviewed by the House of Delegates, give all reasonable assurance that for the dollar paid in dues, the membership is receiving its value.

More than that, because of the very constructive nature of some projects, it may be stated that more than a dollar value of dues,—if the services of the Society are to be measured in any monetary sense, —is returned to the entire membership. Consider the fact, for example, that by reason of membership in the State Medical Society, a sound disability insurance program is available which could not be individually purchased without substantial additional cost. Further, it would not be available then to every member of the Society because it would be underwritten on an individual basis.

The work of Society committees in other fields, such as in the preparation of appropriate fee schedules for certain governmental agencies, assures realistic treatment of these problems. Some services of the Society are so planned as to cover a span of time, such as the panels made available to establishments under the Workmen's Compensation Act. These panels are actually distributed in the even-numbered years, but much of the preparation is in the preceding year. This permits a rather effective program to be carried out at a cost that would be too substantial, were it to be incurred each year.

Staff and Personnel

Under immediate direction of the Council the secretary serves as general manager of the Society's activities; and all personnel of the Society are responsible to him. In turn, he is responsible to the entire Medical Society for effective discharge of staff activities.

The Council appreciates the fact that personnel problems and policies necessarily change with increase in size and complexity of Society activities. The City of Madison presents unusual circumstances. Its largest contributing economic resource consists of the state government, including the University; and employment within the staff of the State Medical Society must take into account the competitive advantages of employment by the state government. The Council has initiated a retirement program which will become effective in 1954. It has also provided the benefits of the Blue Shield-Blue Cross program on a contributory basis.

The Society's executive, administrative, and clerical positions are classified; and routine policies of vacation, sick leave, and other personnel matters have been developed.

The Council appoints independent, consulting certified public accountants, actuaries, and legal counsel so that if in their judgment need exists, recommendations or reports developed by these individuals may be directed to the Council without referral within the employed staff. This is sound practice and was, in fact, initially recommended by the secretary as appropriate to the responsibilities of the councilors and officers.

Conclusion

The Council under the Constitution and By-Laws is the Board of Trustees of the State Medical Society. Under provision of the By-Laws its annual meeting is held in February. It directs that two sessions be called in the months preceding the meetings of the House of Delegates of the American Medical Association so that it may review and advise the Wisconsin delegates with reference to matters that may be considered by the A.M.A. It holds a midsummer meeting, and its November meeting is necessitated not alone by reason of the A.M.A. meeting in the following month, but because it is necessary to acquaint new members of the Council with its activities and responsibilities as soon as possible after the Annual Meeting of the Society in October.

Some problems will be presented with respect to all of these responsibilities and those of the House of Delegates by reason of the fact that the Annual Meeting will be advanced from fall to spring in the year 1955 and in ensuing years.

It should be noted in passing that at the time of this change, it will mean that the Society will complete a "short" year. Its House of Delegates will meet in October in 1954 and again in late April, 1955. Officers elected to assume office in 1954 will serve a shorter period of time, but probably will encounter a more concentrated effort as the change-over is made.

R. G. Arveson, M.D.
Chairman

REPORT ON NECROLOGY

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by boldface type.

Akwa, C. M._Wauwatosa
Berg, W. R._____Gillett
Bowman, F. F.
_____ Waunakee
Bugher, C. E.
Wilmington, Delaware
Burns, R. W._Green Bay
Campbell, E. J.____Cecil
Corbett, J. F._Milwaukee
Curtin, A. L.
Delray Beach, Florida
Curtiss, F. D.__Kenosha
Deicher, H. F._Plymouth
Donnelly F. J.
_____North Lake
Bowman, F. F._Waunakee
Falk, V. S., Sr._Madison
Fiebiger, G. J._Waterloo
Fitzgerald, J. J.___Eagle
Fowle, F. F.__Milwaukee
Grob, A. R. F. Milwaukee
Helmes, L. O.__Oshkosh
Hoyme, Gjermund
__Coronado, California
Hoyt, G. E.
_____Menomonee Falls
Irwin, H. J.
___Pecatonica, Illinois
Jegi, H. A.___Galesville
Kastner, A. L._Milwaukee
Krzysko, S. L. Milwaukee
Lotz, Oscar __Milwaukee
Love, G. R._Oconomowoc
Markson, S. M.
_____ Milwaukee
McIntosh, R. L._Madison
Merten, P. J._Milwaukee
Miloslavich, E. L.
___St. Louis, Missouri
Minahan, P. R.
_____Green Bay
Montgomery, Alexander
_____ Milwaukee
Munn, W. A.__Janesville
Noyes, G. B.___Centuria
Olmsted, A. O.
_____Green Bay
Perrin, S. H.___Superior
Peters, E. E.____Monroe
Peterson, C. F.
_____ Independence
Petzke, E. A.____Hixton
Pfisterer, F. W.
_____ Milwaukee
Purdy, F. P._____Wood
Reeve, J. S.___Appleton
Runnels, D. S._Appleton
Scantleton, J. M._Sparta
Schlenker, G. H.
_____ Amherst
Smith, P. W. Black Creek
Sporleder, O. F._Baraboo
Stanton, E. D.
_____ Reedsburg
Thompson, I. F.___Beloit
Treadwell, C. L.
_____ Friendship
Twohig, J. E.
_____ Fond du Lac
Vachitinsky, Samuel
_____ Milwaukee
von Buddenbrock, Erick
_____ Racine
Walter, G. W.____Racine
Waufle, G. C._Janesville
Wenstrand, D. E. W.
Tryon, North Carolina
Wier, F. A._____Racine
Wilkinson, M. R.
_____ Oconomowoc
Winter, A. E.____Tomah
Young, A. F._Milwaukee

THE COMMISSION ON PREPAID PLANS

E. M. Dessloch, chairman; Robert Krohn; J. S. Supernaw; H. E. Kasten; C. G. Reznichek; N. A. Hill; J. T. Sprague; P. B. Mason; K. H. Doege; H. A. Aageson; R. E. Garrison; R. M. Moore; Richard Foregger; G. W. Carlson; W. C. Stewart; Milton Finn; W. T. Casper; J. C. Griffith, ex officio

INTRODUCTION

During the past year the two prepaid plans under the jurisdiction of the Commission—Blue Shield and the Wisconsin Plan—have undergone the most significant changes in the history of their operation. The obsolete benefit schedule in use since 1946 has been replaced by the new "A" and "B" programs with their revised benefits and full payment provisions. Wisconsin Physicians Service made major revisions in claim handling procedures beginning in the summer of 1952, and many manual procedures have been replaced by IBM equipment recently installed at the Society offices.

Obviously, these changes presented problems for the Commission and the administrative staff of the Society. These matters were discussed in detail by the Commission at its quarterly meetings, as well as by its committees. In addition to numerous administrative revisions necessitated by the new programs, the Commission is constantly faced with the problem of classifying new procedures, developed by advances in the science of medicine, and assigning benefits for them.

During the past 12 months there has been significant progress in the provision of group insurance. Installation of health insurance and service type plans on groups of five or more has been so extensive that potential purchasers among this class are substantially reduced each year. Uncertain national developments have made both management and labor more conscious of insurance cost, as well as insurance protection.

These developments mean that insurance and service-type organizations are selling more in competition and have less potential in completely new installations than was true several years ago. In addition, Wisconsin Physicians Service has been handicapped, and substantially so, during the past 12 months by reason of the fact that it was forced to concentrate on converting existing subscribers to the new programs and could give less emphasis to new sales as a result.

The Commission realizes that the full payment provisions of the Society programs have great public appeal; but it is also cognizant that it is necessary continually to explore new benefit programs, not only to maintain a favorable position, but to serve as a pacemaker in the field. Recently, for example, in-hospital medical benefits, beyond the 30 days provided in the basic program, were made available for subscriber purchase. Executives and other individuals can purchase benefits increased by multiples when their income is such that they are not entitled to full payment.

Studies are under way to provide more satisfactory coverage to persons ineligible for group protection and to develop proposals in the field commonly known as catastrophic insurance. These matters are further developed elsewhere in this report.

A review of the results of the conversion program and the effectiveness of recent benefit extensions indicates satisfactory progress. Virtually all WPS subscribers had either the "A" or "B" plan on July 1, 1953. The majority of the conversions were made in the first half of 1953. During this period, some groups refused to accept the necessarily increased rates; but these cancellations were, for the most part, offset by new sales. The prospects for increased growth during the last half of 1953 are good. This report will outline the status of the more important phases of the operation of the prepaid plans and will comment on future developments.

ADMINISTRATIVE STAFF

The administrative staff continues to function on a departmental basis and, as in past years, receives advice, as does the Commission, on the legal, accounting, and actuarial phases of the program from independent consultants who are specialists in these fields.

Sales Coordinator

Blue Cross, as agent for Wisconsin Physicians Service, continues to be responsible for sales, but your WPS sales coordinator represents Blue Shield directly in negotiations with larger groups. His duties include cooperation with Blue Cross in the development of an appropriate sales policy and in other ways expanding this important function in the protection of WPS.

Periodic meetings of the staff and advisors are held to plan future activities and resolve current administrative problems. Regular bi-monthly meetings are held between the WPS staff and representatives of Blue Cross to coordinate joint activities and bring recommendations for the solution of mutual problems to the respective directing boards.

SALES

Beginning in the summer of 1952, by direction of the Commission on Prepaid Plans, an extensive program was undertaken to change over all current installations as rapidly as possible to the new "A" and "B" schedules. At that time 2,622 groups were enrolled in the program; and it was necessary that they be personally contacted, revisions explained, and conversion to the new programs effected. Physicians should keep in mind that the change from the old to the new program was a substantial one, not only in cost, but in contract provisions, in rate structure, and in sales policies. Simultaneously with the work being done with groups, every effort was being made fully to inform physicians, to install the various procedures necessary to administer the program, and to bring all three efforts into gear so that sales would not be adversely affected by physicians being unacquainted with the program or physician interest disturbed by administrative procedures not being perfected to handle it.

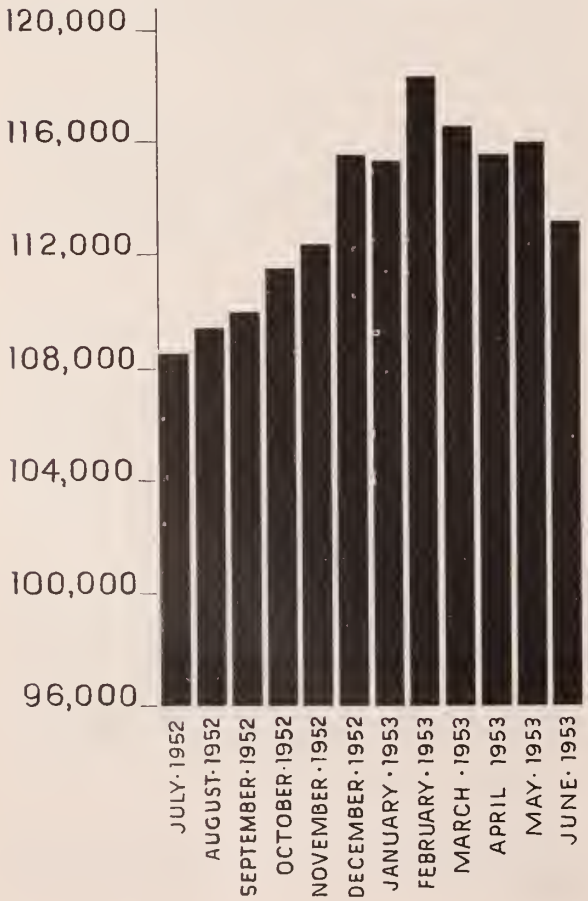
On January 1, 1953, Blue Cross increased its rates on an average of 25 per cent, without any substantial change in contract provisions. This further com-

plicated the problem for Blue Shield inasmuch as the total cost for the Blue Shield-Blue Cross package was increased, in effect, twice in six months—once for Blue Shield and once for Blue Cross. In order to complete the transition from the old to the new plan, the sales force, through Blue Cross, applied extra effort, worked on a rigid schedule, and by and large the conversion was completed on July 1, 1953, as planned. Ten per cent of the groups with which WPS was concerned in the summer of 1952 cancelled the program. The vast majority of these groups were in the small size category and represented only 6 per cent of the total number of people covered.

The losses suffered by cancellation were more than offset by new sales, resulting in an increase in total contracts of nearly 8,000, covering somewhat more than 20,000 persons. In June, 1953, there was a decrease of 3,000 contracts. This decrease was caused by the loss of a nationally negotiated contract. The following graph shows the growth in the number of contracts in effect since July 1952.

With the conversion to the new program now out of the way, WPS can devote much of its time to new installations. Efforts in this direction were necessarily limited during this past year.

NUMBER OF CONTRACTS IN EFFECT



ACCOUNTING

The Council of the State Medical Society itself engages the certified public accountant for the Society, and among his duties is that of making an independent audit of WPS records and accounts at semi-annual intervals. He has made these audits since the inception of the plan and, in his independent capacity, makes whatever tests of the plan's records he feels are necessary, including tests of transactions recorded in detail by Associated Hospital Service, Inc. (Blue Cross), in its capacity as enrolling, billing, and collecting agent.

In addition to his independent position as the Society's auditor, responsible to none of the employees nor to any of the administrative bodies except the Council, the certified public accountant serves as a consultant to the staff and to the Commission in the development of accounting procedures and systems of the plan, and their revision and improvement as is required by the general development of the plan. The basic accounting system was designed by him at the time the first transaction was recorded, and it has been changed and extended with his consultation and advice. The accounting system extends broadly to all functions of the plan which produce documents recording transactions, and thus he has participated in development of forms and procedures relating to adjustment of claims, as well as other matters. Upon request he has studied specific operating problems and has made appropriate recommendations with respect to their accounting aspects. He has advised the Executive Committee of the Commission with respect to development of the investment program. The adoption of accounting machines of International Business Machines Corporation, or the "IBM System" of accounting, was made upon his recommendation after it became apparent that the increasing claim load required procedures to expedite claim handling and at the same time assure adequate accounting controls. The certified public accountant has reviewed assignments of responsibility with respect to the plan's operations in order to provide the highest possible degree of "internal control." This phrase, often misunderstood, is defined as follows:

> "A system under which the accounting methods and details of an establishment are so laid out that the accounts and procedures are not under the absolute and independent control of any one person—that, on the contrary, the work of one employee is complementary to that of another—and that a continuous audit of the business is made by employees."

(Translated into medical terminology, "internal control" is to a certified public accountant what "preventive medicine" is to the medical profession.)

With the volume of transactions representing collection of funds in amounts indicated in the accompanying statements, and disbursement of a high percentage of these funds in satisfaction of claims, internal control is significant in the operation of Wisconsin Physicians Service.

The certified public accountant serves the plan in a third capacity also, in that, upon assignment by the secretary of the Society or by the Commission, he participates in specific major research and development projects which are treated later in this report.

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

BALANCE SHEET
December 31, 1952

ASSETS		
Cash on Hand and in Banks		$ 536,858.21
Cash on Deposit with Agent		121,000.00
Due from Associated Hospital Service, Inc.—Agent		156,743.16
Refunds Receivable		1,961.00
U. S. Government Bonds—Net Book Value	$797,817.96	
Less: Reserve for Losses in Market Value	6,086.96	
U. S. Government Bonds—Market Value	$791,731.00	
Accrued Interest Income	429.18	792,160.18
Office Equipment—Cost less Depreciation		14,479.87
Unexpired Insurance		407.94
Other Deferred Expense		512.71
TOTAL ASSETS		$1,624,123.07
LIABILITIES AND RESERVES		
Accounts Payable		$ 2,729.19
Due State Medical Society of Wisconsin—Current		3,550.84
Physicians Claims Payable		387,308.66
Unrealized Premium Income		302,992.93
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—Maternity Benefits	$180,000.00	
Disaster Claims	138,665.00	
Unforeseen Contingencies	355,159.09	
Cost of Discharging Unpaid Claims	15,000.00	
Administration	195,078.90	
Investments	14,638.46	898,541.45
TOTAL LIABILITIES AND RESERVES		$1,624,123.07

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENDITURES
Year Ended December 31, 1952

INCOME		
Earned Premium Income	$2,655,954.62	
Investment Income	13,121.52	
TOTAL INCOME		$2,669,076.14
EXPENDITURES		
Benefits Incurred	$2,061,032.95	
Expenses of Agent	264,206.29	
Salaries	85,203.51	
Legal Expense	8,502.49	
Accounting Expense	9,275.50	
Actuarial Expense	8,613.34	
Conference Expense	10,812.14	
Staff Travel	4,025.72	
Stationery and Supplies	8,601.85	
IBM Rental, Service and Supplies	2,056.99	
Rent of Offices	6,804.00	
Office Expense	2,196.19	
Postage and Express	4,194.93	
Payroll Taxes	1,947.76	
Telephone and Telegraph	5,603.11	
Depreciation	1,560.63	
Insurance—General	478.73	
Employees Group Insurance	1,143.80	
Association Dues	3,100.42	
Other Administration Expense	1,130.19	
TOTAL EXPENDITURES		2,490,490.54
Available for Reserves		$ 178,585.60
Distribution of Each $100 of Income		
Benefits Incurred	$ 77.22	
Expenses of Agent	9.90	
Other Administrative Expense	6.19	
Addition to Reserves		
Service Benefit	4.42	
Administration	1.78	
Investment	.49	
Total		$ 100.00

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

Comparative Statement of Income and Expenditures
For the periods January 1 to June 30, 1952 and 1953

	1-1-52 to 6-30-52	1-1-53 to 6-30-53	Increase or (Decrease)
Income			
Earned Premium Income	$1,201,344.37	$1,890,712.69	$689,368.32
Investment Income	6,362.76	7,450.76	1,088.00
Total Income	$1,207,707.13	$1,898,163.45	$690,456.32
Expenditures			
Benefits Incurred	$ 994,690.25	$1,530,744.35	$536,054.10
Expenses of Agent	113,089.28	171,793.88	58,704.60
Salaries	37,358.37	54,574.32	17,215.95
Legal Expense	4,615.03	3,492.00	(1,123.03)
Auditing Expense	4,992.75	2,620.59	(2,372.16)
Actuarial Expense	5,479.88	3,125.56	(2,354.32)
Conference Expense	5,566.66	7,748.96	2,182.30
Staff Travel	1,410.76	4,302.77	2,892.01
Stationery and Supplies	4,676.86	4,428.94	(247.92)
I.B.M. Expenses	110.25	3,599.48	3,489.23
Rent	3,402.00	4,950.00	1,548.00
Office Expenses	951.43	1,244.89	293.46
Postage and Express	1,998.68	2,521.21	522.53
Payroll Taxes	963.81	1,739.53	775.72
Telephone and Telegraph	3,238.85	2,469.71	(769.14)
Employee Group Insurance	450.40	767.35	316.95
Depreciation	691.51	925.35	233.84
Insurance	207.52	306.86	99.34
Association Dues	1,495.25	1,722.52	227.27
Other Administrative Expenses	178.09	324.36	146.27
Total Expenditures	$1,185,567.63	$1,803,402.63	$617,835.00
Available for Reserves	$ 22,139.50	$ 94,760.82	$ 72,621.32
Distribution of Fach $100 of Income			
Benefits Incurred	$ 82.36	$ 80.64	($ 1.72)
Expenses of Agent	9.36	9.05	(.31)
Other Administrative Expenses	6.44	5.32	(1.12)
Addition to Service Benefit Reserves	(.74)	1.03	1.77
Addition to Administrative Reserve	2.05	3.57	1.52
Addition to Investment Reserve	.53	.39	(.14)
	$ 100.00	$ 100.00	$

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin

BALANCE SHEET
June 30, 1953

Assets		
Cash on Hand and in Banks		$ 465,152.15
Cash on Deposit with Agent		113,000.00
Due from Agent		135,273.81
Refunds Receivable		2,119.50
U. S. Government Bonds—Net	$998,443.72	
Accrued Interest Income	429.18	998,872.90
Office Furniture and Fixtures—Net		14,937.40
Unexpired Insurance		161.16
Other Deferred Expense		180.00
Total Assets		$1,729,696.92
Liabilities and Reserves		
Accounts Payable		$ 5,258.26
Accrued Expenses		4,117.84
Physicians Claims Payable		332,194.79
Unearned Income		359,736.80
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—Maternity Benefits	$185,200.00	
Disaster Claims	169,672.00	
Unforeseen Contingencies	338,592.16	
Administrative	277,748.89	
Investment	28,176.18	999,389.23
Total Liabilities and Reserves		$1,729,696.92

One of the administrative divisions of Wisconsin Physicians Service is the accounting department, which is charged with the function of recording all transactions of the plan and preparing from such records all reports necessary to guide and inform the Commission and the administrative staff. The financial condition of Wisconsin Physicians Service and the results of its operations are presented for specific dates and operating periods in tabulations on the preceding page:

Included in the accounting department is a statistical division which has been extended during the past year as increasing use of IBM equipment and services has been made. The functions of this division have related almost entirely to claim recording and statistics, but they will expand to other fields as operating changes continue to be made. The experience of this first year with a phase of machine accounting will make it possible for the accounting department and its statistical division to assimilate the ever-increasing number and variety of transactions more easily and to produce tested accounting information more rapidly, necessary not only for recording these transactions but also for analyzing them and interpreting their significance.

CLAIMS

On July 1, 1952, the administration of claims filed with Wisconsin Physicians Service was completely reorganized and departmentalized. Administration was placed under the direction of one individual. A system was established so that any matter which might be asserted as a claim was given a number to carry its identification through all subsequent correspondence to the point of final disposition.

Volume

Actual cases paid have averaged 5,000 per month. This does not include general inquiries, requests for information, or other matters. These cases resulted in the payment of approximately 72,000 separate procedures during the 12 months ended June 30, 1953.

All prepaid plans, including Wisconsin's, have experienced increased utilization the past 12 months. The actual incidence of medical and surgical benefits appears to have substantially increased in Wisconsin and, in the case of medical procedures, primarily because the plans now honor the first day of hospitalization, as distinguished from the obsolete program which provided no benefits until the fourth full day of hospitalization.

Some claims are actually rejected on the basis that while service was rendered, compensation for such service is payable under the Workmen's Compensation Act, or the individual has not yet completed the waiting period imposed for pre-existing and certain other specified conditions.

Studies are being made of the reason for filing invalid claims, for the effort of the Commission is to reduce such "claims" to the minimum in order to hold administrative expense within desirable levels. In most cases, it is no less work for the claims department to handle an invalid claim than it is to handle a valid one.

After review and determination by a Claims Committee consisting of three practicing physician members of the Commission, the medical director and the administrative staff handle cases presenting particular problems that cannot be determined through any existing rule or which require individual consideration. The best example of the latter is the case resulting from an accidental injury requiring extensive suturing and which by no matter of means may be disposed of under a general rule.

Philosophy

The Commission emphasizes to the membership of the State Medical Society that, in a sense, claims administration is handled on a physician self-auditing basis. The claims department could be staffed with technically trained personnel, acquainted in detail with scientific terminology and as fully qualified to interpret and analyze any report as though medically trained. If the claims department were so staffed, claims disposition could be handled more rapidly with less confusion and less dispute; but to so staff the department would increase admintrative expense to the point where benefits of the program would necessarily be reduced or rates increased. Therefore, the philosophy has been developed that actual erroneous judgment by the claims department will be reported by the physician who knows of the payment and that such reports, while perhaps irritating to the physician concerned, nevertheless mean that the plan can operate much more economically than would otherwise be the case.

The results of this policy are periodically reviewed by direction of the Commission. It appears that it is working out in excellent fashion and that individual problems are minimal.

In addition, the Commission reports that not infrequently physicians and their employees contribute to the very situation which causes irritation to them. An operation is reported as exploratory when, in fact, it involved an actual procedure commanding a higher benefit than scheduled for an exploratory; patients are erroneously identified with a medical or surgical procedure; medical care is reported over a lesser number of days than actually given; diagnostic procedures, excluded as benefits when only for diagnostic purposes, are reported without the fact of subsequent surgery; or physicians fail to note other itemized description which is imperative to a satisfactory settlement of their claims.

It is to this end that all services of the Commission have been combined in the educational process that is an inevitable requirement of physicians and their employees alike, as well as an inevitable obligation on their part if Wisconsin Physicians Service is to be, in fact as well as in theory, "The Doctors' Plan."

All statistical information which follows is related to activities of the claims department.

STATISTICS

In July, 1952, the first claim payment was made under the new WPS "A" and "B" schedules of benefits. During the succeeding 12 months, almost one and one-quarter million dollars were paid on the new program. Over one-half million dollars were paid on the "A" schedule. Combining this with pay-

ments made on obsolete coverage, total dollars supplied subscribers in benefits amounted to two and one-half million dollars. Comparative charts on the following pages provide a more detailed picture of these payments.

For the most part the payments were handled through the use of IBM machinery. Planning for an IBM installation was undertaken over a considerable period of time; and the machinery, available only on a rental basis, was first ordered in the summer of 1952. A partial installation, three machines, was made immediately at the Society office, with the balance scheduled for delivery late in 1953.

The IBM machine principle revolves around two basic machine functions:

1. The *preparation* of a "punched card" containing information taken from the approved Physicians Service Report or other source document.

2. The *machine interpretation* of the information from the "punched card" onto tabulated listings, checks forms, or other punch card records.

These two steps are integrated with the WPS claims procedure as follows:

Copies of all approved cases are forwarded to the statistical division where pertinent information is transferred to a card using an IBM key punch machine. The accuracy of this data (patient's name, case number, amount approved, and so forth) is then verified by a machine similar to the key punch. From this point the punched and verified cards are available for processing through the several other machines which perform interpreting, sorting, and listing functions. The machine processing results in tabulated listings, the semi-monthly payment to participating physicians, and reports for internal purposes. Each of these particular operations is the result of a reading process, performed by the machinery, of the coded information contained in the holes of the punched card. Thus far, only the punching and verifying of the card have been done in the Society office. Because the interpreting and tabulating equipment is not available for installation until late 1953, the Madison IBM Service Bureau has performed the additional processing functions.

Through the utilization of the IBM machinery, it has been possible to reduce substantially the volume of checks formerly prepared manually. It has provided both a faster and more accurate means of accumulating information for check writing, statistical reports, national reports, and internal report requirements.

With the addition of four more machines this year, it would be possible to make more frequent payments to physicians if found necessary. A permanent and more detailed report system will be developed. Procedures which would be impractical on a Service Bureau basis, because of time or volume requirements, will also be adapted to the machine installation. For example, a "punch card check," similar to that in use by governmental agencies, would permit more frequent payment at a lesser cost because of machine application.

Several statistical charts and tables follow with explanatory material.

WISCONSIN PHYSICIANS SERVICE
COMPARISON OF INCIDENCE AND COST OF FIVE BASIC ELEMENTS OF COVERAGE

	Procedures Performed per 1,000 members per year		Per cent of Increase	Dollars Paid per 1,000 members per year		Per cent of Increase
	12 months ended 6-30-52	12 months ended 6-30-53		12 months ended 6-30-52	12 months ended 6-30-53	
Surgery—In Hospital	102	124	23.5	$4,713.60	$ 5,538.60	17.5
Surgery—Home and Office	29	31	6.9	320.52	386.57	20.6
Medical—In Hospital	40	58	45.0	600.96	1,421.28	136.5
Obstetrics	44	45	2.3	2,614.12	2,720.16	4.1
Anesthesia	12	17	41.7	119.16	235.20	97.4
X-ray	9	15	66.7	54.35	95.14	75.1
Total	236	290	22.9	$8,422.71	$10,396.95	23.4

The above tabulation presents services and dollars paid per thousand persons covered during the 12 month periods shown. Percentage increases are also shown. The most significant changes were in medical care, anesthesia, and x-ray benefits provided. The decided increase in medical care incidence (procedures) is due primarily to the expansion of this benefit under the new program to provide coverage during the first three days of hospitalization. A part of the increase may have resulted from increased use of hospital facilities. An expansion of hospital building programs during the past year also had its effect. A percentage increase in dollars paid, greater than the percentage increase in incidence, is due to the first day benefit ($10 "A" schedule and $8 "B" schedule), which is considerably higher than that provided for the remaining hospitalization up to 30 days. A further reason is the acceptance of the five element (surgical-medical) contract by subscribers during the changeover to the new program since July 1, 1952. Only 4 per cent of the contracts changed over chose to exclude medical care benefits.

Both anesthesia and x-ray benefits show a substantial increase. Prior to July 1, 1952, all "surgical only" contracts sold excluded not only medical care but also anesthesia and x-ray. Contracts sold after that date do not provide a choice of the latter elements, and because several large groups formerly had obsolete surgical only contracts, in addition to many direct pay subscribers, an increase in the incidence of these two benefits was certain. At the present time, all contracts outstanding have been converted to the new program and include both anesthesia and x-ray. An even greater increase was experienced in dollars paid per thousand members for these two items. This reflects the improved benefit schedules.

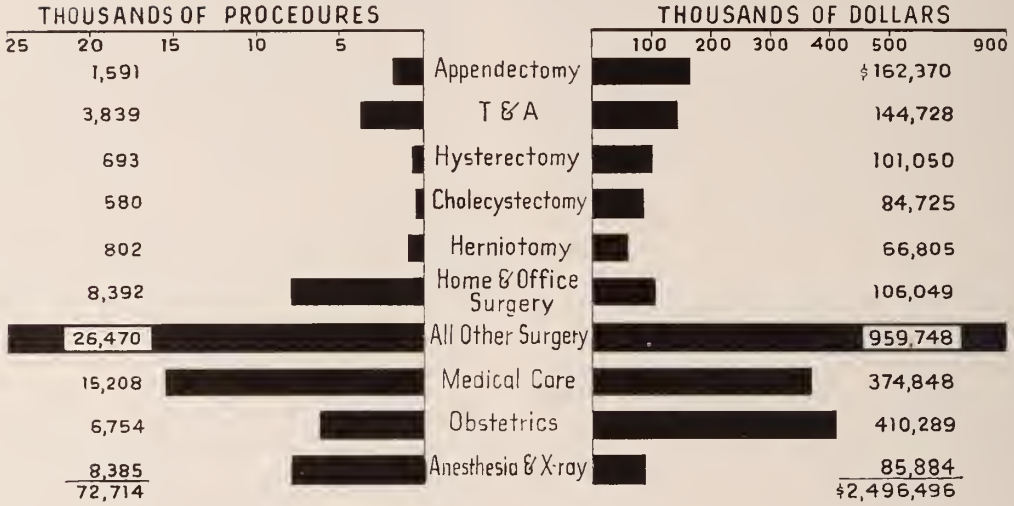
The other three classifications, in-hospital surgery, home and office surgery, and obstetric services, also reflect increased use of available benefits by subscribers and the improved fee schedules.

Some general reasons for increases in incidence and cost are as follows:

Expiration of waiting periods on group and non-group coverage.

Increased use by subscribers as they become more fully aware of existing benefits. This is particularly true of home and office surgical benefits added in

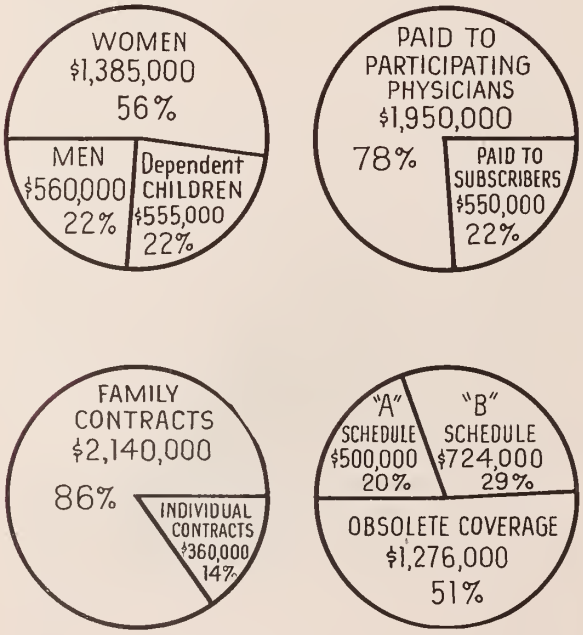
WISCONSIN PHYSICIANS SERVICE
Claims Paid During 12 Months Ended June 30, 1953
By Type of Procedure



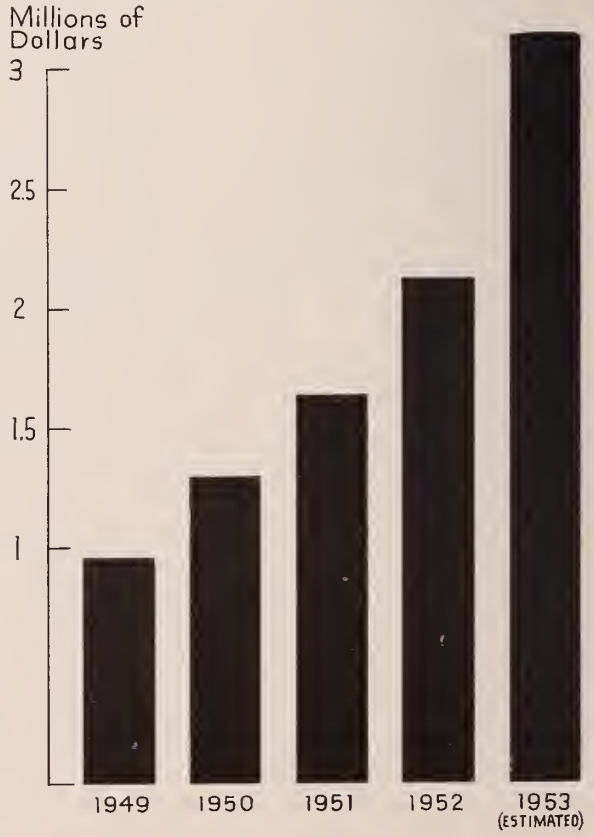
WISCONSIN PHYSICIANS SERVICE PAYMENTS

During 12 Months Ending June 30, 1953

Total of $2,500,000 Paid For



WISCONSIN PHYSICIANS SERVICE
Incurred Utilization 1949–1953
This Chart Shows Benefits for Services Rendered in Each of the Calendar Years Indicated



1951. The increased utilization of this item is in almost direct proportion to the aging of the subscriber's contract.

A further reason, and the one which had the greatest effect on WPS coverage during the past 12 months, is the liberalization of contract benefits.

At the time of this report, 35 per cent of WPS subscribers had purchased the "A" schedule. Benefits under this and the "B" schedule were much improved over the obsolete program and account for a large part of the change in cost per thousand members covered. It should be pointed out that even greater increases are certain when the full effect of the new program is felt. The 12 months which ended June 30, 1953, was the changeover period. It included experience on the obsolete schedule; and all benefits, medical care in particular, should show further changes next year. It is estimated that the year 1953 will result in payment of over $3,000,000 for physicians' services. If this is realized, it will exceed the cost of services rendered in 1952 by over $1,000,000 and will be more than double that experienced during 1951. Approximately 82 per cent of this payment will go to group subscribers with another 12 per cent to former group subscribers now holding conversion contracts. The remaining 6 per cent will be provided nongroup members.

Claims experience is improving in some respects. Just two of the reasons are better enrollment and claims underwriting procedures and aging of outstanding contracts to the point where many of the certainty procedures, "one time only per contract," such as tonsillectomies and adenoidectomies, appendectomies or herniotomies, have been performed. This fact will be more evident each year but will be offset by the new contract sales which add "unaged" coverage.

FIELD SERVICE

Within the last year, administrative staff changes have been effected so as to include a field secretary who assists in the explanation and development of many of the Society's programs, including the prepaid plans.

Physician Employees' Meetings

The Physician and Public Relations Committee recommended to the Commission the development of meetings throughout the state for employees of physicians who assist in the preparation of reports to WPS and who frequently are contacted for advice as to the benefits and other provisions of the plan.

Thirty-five meetings have been conducted in as many different cities. Attendance totaled 638 persons representing about 900 physicians.

The Blue Shield contracts were analyzed, recommendations offered relative to reporting services rendered, other procedures relating to claims described, and a general question-and-answer period provided.

Since the initial series of meetings, inquiries have been directed to those in attendance asking their evaluation of the meetings, their value to them as physician employees, and other questions pertinent to their future conduct. The replies show general agreement that the program is of substantial value, and the Commission has authorized its continuance in the year 1953–54.

Participating Physicians

By decision of the Commission, booklets are published annually, listing physicians who are participating in the prepaid plans and who have accepted the full payment provisions of those plans. Each year it becomes necessary to offer this opportunity to those who have recently joined the Society, as well as those who have not previously enrolled, sometimes by reason of the fact that they were in military service.

The most careful studies of physician distribution in Wisconsin have been consulted, with the conclusion reached that, subject to periodic adjustments, there are 2,807 physicians available to the general public through private practice. A total of 2,205 physicians have enrolled as participants, leaving a balance of 602 physicians who, because of professional commitments, may be unable to participate, refuse to participate, or have made no reply to solicitation inquiries.

Thus, 78 per cent of Wisconsin physicians participate in the full payment provisions of the program, and it should be emphasized that withdrawals were very few in number. In addition, in one area of the state there is virtually no participation on the part of the membership of two county medical associations; and in a number of counties participation is 100 per cent.

PUBLIC INFORMATION

Significant changes in Blue Shield advertising and promotion have accompanied the expansion of WPS benefits during the past year. Public information activities have accentuated the philosophy that Blue Shield, as an economic device, is intimately associated with the satisfactory relationship between the doctor and patient, so essential during a period of disturbed health. Public relationswise, underwriting, advertising, sales, and claims payment are all part of this essential relationship.

While the quality of WPS advertising and promotion has increased substantially during the past year, perhaps the most important change has occurred in its character. Previous attempts to write joint advertising for three prepaid plans produced institutional ads—good for building public acceptance of health insurance, but relatively ineffective in selling Wisconsin Physicians Service as a specific and desirable program for personal and family protection. Currently, all WPS mass media advertising is designed to produce results—to create a general desire for prepaid health protection, to convince present subscribers of the wisdom of their choice, and, most of all, to sell new WPS business. Alternate newspaper ads are devoted entirely to Blue Shield or Blue Cross, thus enabling each program to be identified with the benefits and advantages it offers.

The "fear" element has been eliminated from advertising and promotional copy. No longer is the doctor pictured as an ogre waiting in hiding to bludgeon the hapless sick with giant medical bills. Undoubtedly, the constant reference to the inevitability of huge medical bills, bankrupting costs, and

Daily Newspapers Using Blue Shield-Blue Cross Ads

overburdening charges in the health insurance ads of recent years has contributed significantly to the public's unfortunate and undeserved conception of the physician as a soulless profiteer.

Since June, 1953, the Blue Shield-Blue Cross advertising program has consisted of ads in every daily Wisconsin newspaper from one to three times each month, and in nearly 70 weekly newspapers at least once a month. By simply taking advantage of a technical process in the Milwaukee daily newspapers, WPS is able for the first time to place its specific message in more than 150,000 copies of the Milwaukee *Journal* and Milwaukee *Sentinel* delivered daily to subscribers outside Milwaukee County. Also, for the first time, Blue Shield and Blue Cross are utilizing the medium of radio. A total of 21 stations carry several spot announcements each week.

Maps are included in this report showing distribution of radio stations using Blue Shield-Blue Cross spot announcements, and daily and weekly newspapers carrying their ads.

Weekly Newspapers Using Blue Shield-Blue Cross Ads

Radio Stations Using Blue Shield-Blue Cross Spot Announcements

In the placement of advertising with newspapers and radio stations, every effort is made to associate WPS with the State Medical Society to develop its recognition as "The Doctors' Plan."

Blue Shield and Blue Cross will jointly expend a total of nearly $75,000 for advertising in daily and weekly newspapers, labor, religious, and other special interest publications, and radio. The share of Wisconsin Physicians Service will be about $15,000.

In addition, the cost of promotional literature, direct mail, community enrollment advertising, and other publicity will be borne according to the agency agreement. All literature and advertising for WPS are approved and supervised by the staff.

It should be remembered that WPS subscribers do not, of course, just select Blue Shield by chance. A combination of circumstances brings about their enrollment. The role of advertising, as a producer of prospective subscribers, is extremely important,

though often underestimated or overlooked. Sales are the result of long-time planning, and advertising produces long-term results. WPS general advertising does its best to build up an interest so powerful that it persuades a lot of individuals to accept the idea of purchasing prepaid health protection. It may be the first or the tenth ad that causes a particular prospect to send in the coupon. It may be the piece of literature that comes in the mail that turns the tide of inquiry. It may be that the representative's call is more successful because of the preliminary idea-planting done by advertising. All are important to the sale of new business and the retention of present subscribers. Nevertheless, advertising remains one of the big "prospect-getters," whether it affects thousands of prospects, who are unable to identify their interest in health insurance with any particular bit of stimulation, or whether it is the final impetus which prompts the reader, listener, or viewer to select WPS to provide his prepaid protection.

The Commission authorized the Physician and Public Relations Committee to produce a Physicians' Manual on WPS for the use of physicians and their office personnel. The manual is scheduled for distribution to all physicians, hospitals, and sales personnel. It is believed that it will make a significant contribution to better understanding of WPS by physicians and their employees, improved claims payment, and more satisfactory subscriber relations.

The staff was invited to participate in the proseminar on family financial security education, held during the University of Wisconsin summer session for secondary school teachers responsible for instructing children in this field. It is believed that this opportunity to present information about the need for, use, and availability of health insurance constitutes a significant public relations achievement for the entire industry, as well as the medical and hospital professions. The knowledge imparted during this session is certain to be repeated many times in classes throughout the state and nation.

The Physician and Public Relations Committee foresees an active future. The development of an annual report on Wisconsin Physicians Service for both physicians and subscribers seems a necessity. Such a report will serve to inform doctors and subscribers of the progress of their plan, as well as develop a deeper understanding of the Blue Shield philosophy.

WPS is gearing its future advertising program to "tie in" with the national Blue Shield and Blue Cross advertising campaign which will be carried in *Life*, *Look*, and the *Saturday Evening Post*. Duplication of the format, layout, and copy ideas in local media is certain to multiply the impact of the national program. The Commission has approved WPS participation in the cost of the program on the basis of .15 per cent of its annual premium income.

Advertising through the medium of television appears to be almost a certainty. The growing number of television stations in Wisconsin offers an unusual opportunity to present WPS to thousands of persons who have never before been exposed or attracted to Blue Shield. Despite its "dramatic" cost, television actually produces results at an amazingly low cost per thousand contacts in well-established TV areas.

Current studies of these and other matters are now under way.

RESEARCH AND DEVELOPMENT

When the House of Delegates in 1951 approved the special report of the Council with respect to the prepaid plans, the Commission on Prepaid Plans and others concerned with their execution necessarily were required to concentrate their entire effort in the preparation of the new contracts, enrollment and underwriting regulations, new statistical requirements, and many other important administrative details. Following their completion, the next most important task before the Commission was to take such steps as would assure the early availability of the new program to the public. With that availability, important pressures, as indicated elsewhere, were required to convert risks earlier sold under obsolete coverage and to maintain in the best manner possible sufficient new sales to offset cancellations.

As it became apparent that the new program was being successfully handled, the Commission next directed its attention, through various of its committees, but principally that on Research and Development, to needed expansion, to certain research problems looking toward new developments, and to other matters of similar concern. In all of this, the Commission and its committees have had the advice and the active participation of legal, accounting, and actuarial consultants along with general staff assistance.

Optional Riders

Several additional coverages have been made available, each requiring careful legal phrasing and relation to accounting and actuarial problems.

Uniform expansion of the schedule "A" benefits, in group policies only, in multiples of 25 per cent up to a maximum of a 100 per cent increase over the "A" level, is available at added cost to those individuals whose earnings are such as to make them ineligible for the full payment provisions of the primary contract. Thus, those receiving such increased benefits obtain them wholly on an indemnity basis; but they are provided with a more realistic benefit in relation to their potential liability.

Blue Cross provides hospitalization benefits for periods of 30 days, 70 days, and 120 days in various contracts. It was felt that in-hospital medical care benefits, provided in the primary WPS contract for 30 days, should be available at the option of the purchaser and at additional cost, so as to be coextensive with Blue Cross hospital care benefits. This has been accomplished, and the rider is now available.

In the development of most insurance programs, medical care benefits for the newborn infant generally are eliminated, and customarily surgical benefits are not available until the infant has attained the age of at least 14 days. Medical science in recent years has found the complete replacement transfusion an advisable procedure in cases of erythroblastosis; and this procedure, together with circumcision, constitutes a substantial number of surgical procedures in the first 14 days of life. Surgi-

cal benefits for the newborn are now an optional WPS coverage at additional cost.

Dependency coverage has terminated under the primary contract at the end of the month when the dependent reaches his nineteenth birthday. Conversion privileges are available, but enrollment of the dependent under the conversion contract is administratively difficult when there is no practical means of placing individual names on a follow-up system based on their birth date. Consequently, the present contract terminology has been liberalized administratively, and probably will be liberalized in its next reprint, to provide that benefits for dependents cease at the end of the calendar year in which the dependent reaches his nineteenth birthday. This will mean that a blanket effort to enroll such dependents under conversion contracts or other types of contracts may be undertaken at one period each year.

Other steps have been taken to bring about more uniformity with Blue Cross, and by Blue Cross with WPS. For example, a special contract is written by Blue Cross known as the "Auto" contract, available to certain industrial risks. Because of union negotiation, maternity benefits under that particular contract are made available to female employees having benefits provided themselves and not their families. There are a great number of working wives, and it appears to be a tendency in many negotiations to consider them as a single person rather than as head of the family. Blue Shield will provide maternity benefits under uniform administration with Blue Cross; and as experience is gained, it may well be that this pattern will be made uniform throughout the service contracts written.

Catastrophic Insurance

Physicians in Wisconsin, as elsewhere, should give early consideration to the future impact of so-called catastrophic or "dread disease" insurance. It must be apparent even to the casual reader that the insurance industry generally has either entered the field to a limited extent or is considering doing so. By comparison with the millions of contracts providing basic benefits for hospital, surgical, and medical needs, and if those needs are related to acute conditions, installation of catastrophic insurance is not substantial, but is of sufficient consequence so that it is a pattern of future development without question.

Probably California Physicians Service entered into this field in the first generally constructive effort. Polio policies have been a rather common development. Special accident policies, such as those issued to hunters, have been of relatively recent origin. For some years it has been possible to purchase insurance protecting against the hazards of commercial air travel through the convenience of coin-operated machines at airports.

The Commission on Prepaid Plans itself, as well as its Committee on Research and Development, has been provided with much detailed information; and it is anticipated at the time of writing this report that such a program can be offered by it during the course of 1954.

Planning is not only under way but has been carried to a substantial point. The program is intended to supplement existing coverage. It will act as a kind of "overdrive" to take effect approximately where the basic or primary coverage ends. There are many problems, administrative and financial, associated with it; and these are in course of discussion and settlement. Legal, actuarial, and accounting questions are numerous. How shall the limitation of benefits be defined? Is it to be expressed in terms of dollars only? Of time only? Of a combination of dollars and time? In terms of each disability?

Should there be a ceiling as to benefits for all disabilities within a certain period or within a family during a certain period? What are the major benefits that must be provided if this program is to serve its intended purpose? What related training and skills and commodities should be included? Should the concept of a type of full payment be included to the point that the benefit will pay all reasonable charges of physicians and surgeons, taking into consideration the practice of the medical community as well as the needs and problems presented by the patient?

A detailed report on catastrophic insurance would, in itself, be a considerable volume. The planning of one large insurance carrier, which has now announced its program to its agents, involves typewritten material in excess of 40 pages—and this to explain a program to those acquainted with all insurance principles.

The program of catastrophic insurance, when it is finally perfected, will be submitted to the Council for its approval and action; but the Commission desires to report that it is in something more than a contemplated state. It is in process of actual development and early installation.

Community Enrollment

It has been pointed out elsewhere that the installation of voluntary insurance has reached the point where, to use an insurance term, its potential installation on groups is largely a matter of competition, as there are comparatively few groups which are not now purchasers of some kind of protection.

That means that voluntary insurance, in a general sense, has achieved a very considerable portion of its objective. It does not mean, however, that the objective has been achieved of wide availability of the full payment principle. The road ahead for enrollment new to Blue Shield will be harder because it will be more competitive; but the importance of the full payment principle as a highly desirable and important feature to the beneficiaries will be demonstrated increasingly.

Apart from the true group field, there remains a substantial area of service yet to be performed. There are a great number of individuals in Wisconsin whose status is not that of an employee in a group. They are individual operators, owners, or businessmen; some of them are reaching an age entitling them to at least partial, and perhaps full, retirement. Others are youngsters partially employed, perhaps still carrying on with educational efforts, and some of them are returned servicemen whose plans are not as yet well defined. In this whole field of breadwinners and dependents alike, there is as much need of voluntary insurance protection as though those people occupied a different position entitling them to group protection.

Out of this situation generally, and to serve the purpose of the program in other respects, it has been decided to undertake, experimentally, a program known as Community Enrollment. Under that, in at least several areas of the state, the population of the community, not otherwise enrolled, will be considered a type of group, for practical purposes. A campaign has been planned to interest them in the purchase of Blue Shield. The broadest type of coverage will be offered under rates especially devised by our actuaries for the purpose. Special statistical records will be kept; and the experience gained by permitting people to enroll in this coverage, during only a limited period of time and only in a well defined area, will subsequently be related to the Council and through it to the House of Delegates. Controls are such that this special type of enrollment will not be of sufficient percentage in relation to WPS total installations as to constitute a serious financial hazard should utilization prove wholly adverse.

Merit Rating

In 1952, the Commission approved a group merit rating system recommended by the actuaries to replace a "cost-plus" arrangement. "Cost-plus" was not consistent with the basic insurance principle of spreading the risk. Group merit rating retains the principle of pooling the pure risk but does reward better-than-average groups for favorable claims experience. It also establishes a system of rating for adjustment of the premiums in relation to the inherent risk characteristics of each group or group category.

Statistical tabulations have been developed by group size categories for use in evaluating each group's experience in comparison with normal expected losses. Those groups with loss ratios below the normal are eligible for premium refunds within prescribed limits. Others with loss ratios below these limits may also receive a rate reduction. Groups above the normal loss ratio may require rate increases. In all cases, groups must fulfill contingency reserve requirements over a period of time related to the group's credibility, which is a function of group size.

This program is now in effect for all groups with 150 or more enrolled subscribers. The first annual reports for these groups indicate that some will be eligible for rate credits or refunds in 1953. Premiums for other groups may be increased, necessitated by the group's actual utilization.

Merit rating tends to stabilize the over-all rate structure of Wisconsin Physicians Service by retaining in the plan the good risks through proper rating and refunds, and by elimination of large financial losses for groups that are inherently poor risks. It also should be an important sales tool and should substantially improve group relations.

Need for Statistics Never Ends

The tremendous advances in scientific medicine, public health education, and the wide acceptance of the voluntary insurance principle have brought about an increasingly well educated public. New procedures become known as they become perfected and their soundness demonstrated. New surgical procedures may eliminate, almost to the point of obsolescence, a procedure that once was quite common. A common medical condition of yesteryear may virtually disappear sometimes within a matter of months. The rate which subscribers pay for the protection of Blue Shield and similar plans must be based upon a combination of elements if those rates are to be determined with sufficient accuracy not to require such frequent readjustment as to defeat the very purpose of the plans.

One element is that of the known amount of the benefit to be paid for a specific procedure. A second element is to know under what conditions such a procedure will be recognized as entitled to the contract benefit. This is perhaps best illustrated by voiding a benefit under Blue Shield where the procedure is compensable under the Workmen's Compensation Act. A third and much more difficult element to determine is the frequency with which a procedure will be incurred as a benefit payment.

There are many insurance principles that must be followed with meticulous attention in order to assure that the statistical information will be valid and offer a sound basis from which to predicate the rates to be charged for the benefits. This is a technical field and not one which need be included in this particular report; but ultimately the problem brought about the conclusion that the medical profession in Wisconsin should be serviced in this program and in related activities by the profession of actuarial science.

Actuaries advising WPS, in connection with the staff, assist in the development of mechanisms for the maintenance of claims information on IBM cards. In the period of the last 12 months, the "deck" of cards prepared by the statistical division of WPS totals 150,000!

These are periodically tabulated in various ways; and from their summaries, and related to contract terminology and enrollment regulations, actuaries review experience and project trends to aid the Commission in policy decisions. The opinion of these advisors is that the plan is operating on a sound financial basis and with an appropriate rate structure.

CONCLUSION

On behalf of the Commission, for which this report is submitted by its Executive Committee, acknowledgement must be given to the effective and constructive action of those members serving on the various committees of the Commission. The Claims Committee is required to meet often, and on subjects that can hardly be characterized as either noncontroversial or simple. The Blue Cross Committee is charged with special liaison with that organization with which Blue Shield has so much in common. The Enrollment and Underwriting Committee reviews suggestions of the staff and consultants and finally recommends to the Commission those enrollment regulations designed to provide the greatest possible degree of stability to beneficiary and plan alike. Enrollment and underwriting rules are basic to the sound structure of the program. A risk that does not present itself as average cannot be made average simply by charging it more. Much of the work of the Research and Development Committee already has been described, as has that of the Phy-

sician and Public Relations Committee. The Executive Committee meets often, and its agenda include many items of immediate importance. Under the structure of the Commission, it is responsible for these reports to the Council and others.

Through physician and staff representation, Wisconsin Physicians Service has participated in a number of national and area meetings. When national meetings of the Blue Shield plans are held, the Commission has authorized the distribution of a report to the entire membership as to the principal activities of such meetings.

All in all, from July of 1952, the date of the last formal report, to July of 1953, when information for this report was compiled, it may be said that we have had a successful and effective year.

THE WISCONSIN PLAN

The Wisconsin Plan preceded Blue Shield in origin; but it has been passed in the race, the responsibility for which is shared, in a sense, by the Commission and by its staff as well as by the participating insurance carriers. The Wisconsin Plan, created by the State Medical Society, has served a most useful purpose; and with time now available by the Commission and by the staff to give it more attention, it is believed that it can and will continue to serve that purpose in the entire field of prepayment plans.

An observation should be noted here of a fact that is not always readily apparent; yet, it causes important problems to the companies participating in the Wisconsin Plan. In addition to surgical-medical insurance such companies provide related programs in the fields of hospitalization, time loss, accidental death and dismemberment, and life insurance. Thus, such companies are presenting a larger "package" than does Blue Shield-Blue Cross, and consequently, a more costly one. Insurance companies, along with every other organization providing hospitalization insurance, have experienced difficult problems in light of increased hospital costs and factors which have brought about higher utilization of all forms of primary coverage in the health and accident field.

In many installations, with the cost factor of the entire package an important one to the purchaser, the surgical-medical schedule approved by the Commission on Prepaid Plans has been dropped in favor of a lesser benefit; but this does not indicate a lack of support to the principle of the plan.

Eleven large insurance companies participate in the program and reimburse the Society all of the expenses incurred by it in the Society's administration of various responsibilities. The costs of claim advice, answering inquiries, reviewing policies, preparing the panel of participating physicians, postage, form letters, and clerical and stenographic help are maintained in detail by the Society; and a sufficient annual deposit is made by each insurance company to cover the bulk of these expenses. If the deposit is too large, a credit is arranged for the ensuing fiscal year; if insufficient, participating companies contribute whatever additional amount is necessary.

All policies of participating companies bearing the designation of the Wisconsin Plan have been reviewed in detail by the staff and by our legal consultant. Uniformity and compliance with Society specifications have been achieved in all cases. Insurance companies, and in particular their claim departments, have received a liberal amount of education during the years of the existence of the Wisconsin Plan as to physicians' fees, what is an adequate fee, problems of medical and surgical procedures, and what are inadequate policy provisions. In turn, insurance carriers have provided much "know how," and have done so generously and constructively, to the staff of the Society in various problems which the staff has encountered. For example, the director of the WPS claims department and a representative of the certified public accountant spent two days in claims departments of Wisconsin insurance companies studying their procedures and mechanisms to assist in developing the WPS department. Insurance companies have provided extensive information in the field of catastrophic insurance; and while there is competition between Blue Shield and the insurance companies, principally those of Wisconsin, the competition has tended to become increasingly friendly, but none the less vigorous.

Blue Shield has demonstrated to the insurance industry what can be done. It will take time to demonstrate that it is being done soundly and in light of needs and demands of the public. But between the two, the advance of sound insurance programs in the state seems assured.

During the ensuing year the Commission intends to prepare periodic bulletins for circulation to participating companies and to engage in regional conferences that will aid in developing the Wisconsin Plan further.

It is not possible for the Commission at this time to report on enrollment and general experience of the Wisconsin Plan, principally due to the fact that the companies, engaging in a program involving the same problems as Wisconsin Physicians Service,—that is, converting from old to new contracts,—are not prepared to develop their statistical information. Such reports will be submitted at later dates.

COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., chairman; J. D. Steele; R. F. Purtell; T. L. Tolan; R. G. Piaskoski; J. A. Schindler; E. H. Pawsat; H. W. Carey; H. A. Sincock; E. D. Schwade

Organization of Commission

The State Medical Society has a long history of public health studies and recommendations developed through various committees whose activities were generally confined to special fields. Results of such work have produced an admirable record, of which physicians in Wisconsin may well be proud.

In the past decade, however, governmental and private agency extension into public health fields has

become increasingly complex. The federal government has many departments, agencies, and divisions representing varied activities at that level. While the state is less intricate, nevertheless its work has been at increasing tempo.

Under the former type of committee structure, each having specific assignment and reporting to the House, coordination of responsibilities became more difficult. The determination of a particular policy in one field could well set the pattern in another at some later date. A committee serving one particular department was not always aware of related activities in another state department and often did not have opportunity to consult with it. Rapid developments in a particular field require ease of handling its medical aspects.

Therefore, it became increasingly evident that such a situation required within the State Medical Society itself, a reorganized structure composed of interested physicians, willing and able to serve. With approval of the 1952 House of Delegates, it was decided to accomplish these various objectives by creation of the Commission on State Departments through Council organization and supervision to the point that this Commission would be currently active.

Commission and Division Structure

Membership of the Commission is composed of 10 physicians, each elected by the Council for terms of one year. One of these is elected as general chairman, and the other nine are chosen so that general practice, as well as specialty interest, is represented. Individually, in consideration of nominees, such special fields of interest are considered as: tuberculosis and chest diseases, rehabilitation, handicapped children, maternal and child welfare, mental hygiene and institutional care, school health, public assistance, geriatrics, hearing and visual defects, and others.

The chairman of the Commission is in general direction of its work, and each of the other nine members serves as chairman of one of its nine divisions. Divisions of the Commission have been worked out in such fashion as to roughly parallel various state and other activities in public health. The division chairman presents to the Commission as a whole his recommendations as to membership in his division. Each division, if it so desires, may designate committees in some specialized study.

In addition to the 10 members of the Commission, there are 49 physicians serving on the divisions, and another 14 on special subcommittees. Thus, 73 physicians are now representing the profession in these fields of public health interest, with at least annual report to the entire Society through the Council and the House of Delegates.

The over-all Commission has met several times during the year to review recommendations of divisions and to advise directly with the heads of state departments immediately concerned with division activity. To date the major emphasis has been directed to health programs in the Department of Public Instruction, the State Board of Health, the Board and the Department of Public Welfare, and the Board of Vocational and Adult Education.

The first year's work of the Commission and its various divisions has amply demonstrated the wisdom of coordinated action. When similar health activities are being carried out through various state agencies, there is need for a consistency of policy; and meeting with the heads of the various state departments has achieved uniformity of action which is highly desirable and of direct benefit to the citizens of Wisconsin. Likewise, it has provided an opportunity for the State Medical Society officially to serve in an advisory capacity to the several state departments and to assist with the organization of programs of direct concern to physicians and public alike. It has given the Society a voice in the determination of policies which are consistent with good medical practice and in the best interests of the public health. The Council and the House of Delegates are to be complimented upon the wisdom of providing a coordination of activities in these various fields, which will result in better understanding between state agencies and the physicians of Wisconsin.

DIVISION ON CRIPPLED CHILDREN

H. A. Sincock, chairman; J. W. Nellen; D. W. McCormick; R. C. Waisman; M. G. Peterman; K. P. Newcomb; F. D. Bernard; A. B. Weinstein

The division has reviewed various programs of the Bureau of Handicapped Children and bases its report on these governmental activities. These activities fall into the following categories:

1. *Orthopedic Clinics.* The report of the medical director of the Bureau indicates that a decreasing number of patients are seen at the clinics, which seems to indicate that a better distribution of orthopedic services outside of Milwaukee and Madison has resulted in earlier local or regional evaluations by specialists. This is a good sign and will offer an opportunity for the Bureau to re-evaluate its program and intensify services in those areas which do not have the services of specialists in neighboring counties. The report further indicates that there has been a growing tendency to use boarding homes for children requiring long treatment at the orthopedic schools, rather than transporting back and forth, or using a number of homes on a short-stay basis.

2. *Rheumatic Fever.* Special attention has been directed to the outpatient service conducted on a trial basis at St. Mary's Hospital, Madison, where diagnostic services are provided through direct referral, and reports are sent back to the family physician and the family, where home care is provided through the help of the Visiting Nurses Association; and "home-bound" instruction is provided through the Madison Public Schools.

Considerable discussion has been directed to the pros and cons of convalescent home care. While there was no complete uniformity of opinion among the members of the division, it was generally agreed that the cost of convalescent home care was high

and not practical except in a few populous areas. Even there the services have to be closely related to a general hospital to be successful. It was the feeling of many members that it would be desirable to have a team of specialists come into a specified community at periodic intervals to review with the family physicians cases which need special study. Some members questioned this approach unless a planned program of "follow-through" could be assured, so that the therapy could be conducted properly through the family physician. Lack of nursing care was also cited as one problem in home care of rheumatic fever patients.

While the division is not unanimous in its present evaluation of the convalescent home care program, and at this point is not prepared to present a specific report on its further development or modification, it has agreed that county medical societies and other groups concerned with the problem need some basic principles to follow, and in keeping with this feeling the division has prepared a basic outline for the development of a rheumatic fever program which it is hoped will be used extensively.

3. *Cerebral Palsy.* Admittedly there is need for more work being done for the cerebral palsied child. While the Bureau of Handicapped Children is concerned with this problem, the major activity in the field has come through the Wisconsin Association for the Disabled. In cooperation with the Council on Scientific Work this agency, through the Milwaukee Cerebral Palsy Center, has set up a demonstration, conducted from 9:00 to 10:00 a.m. each day of the Annual Meeting, which will afford all physicians a better concept of services available, therapy used, and ways in which the Milwaukee Center can be of service to patients outside of Milwaukee County itself. It is estimated that there are approximately 3,000 children under 20 years of age with cerebral palsy in Wisconsin, so it can be seen that a coordinated program to serve the entire state is sorely lacking. While certain populous areas can and should support a continuing service, there are other areas which can only be served on a periodic clinic basis. It has been recommended by this division that the Bureau of Handicapped Children, in cooperation with the Wisconsin Association for the Disabled, set up a few demonstration clinics, patterned after the orthopedic clinics, with teams of specialists in attendance to conduct intensive evaluations of patients, upon referral. Again, it is emphasized that such clinics can only reach their ultimate goal if the family physician works in closest cooperation, preferably by attendance at the clinic itself and taking part in the evaluation of patients he has referred for study.

Many other classifications of handicaps have been reviewed by the division. The problems of the epileptics are well known to the medical profession; and while increasing attention is being directed to the control of seizures, there is still need for public, as well as professional, education on this subject. Likewise, the special problems of the children suffering from cleft palate present problems, both medical and social in character. Increased facilities for the special education of these children are being provided, and physicians should become well acquainted with the avenues through which their patients may receive aid.

Recommendations

1. County medical societies re-evaluate the need for orthopedic clinics in their areas, in cooperation with the Bureau of Handicapped Children, and where modifications to the present program are needed, make such changes without in any way lessening the effectiveness of a proper diagnostic service available to family physicians and their patients.

2. County medical societies study the best avenues through which rheumatic fever patients in their areas may be served, giving proper attention to the possible services of a convalescent home, to outpatient service, and to proper facilities needed for an effective home care program. It is further urged that county medical societies assist well-meaning local groups who suggest establishment of special facilities, to make sure that such facilities can be justified on the basis of potential patient load, availability of proper medical, nursing, and educational facilities, and other factors which contribute to the success of such specialized services.

3. The Bureau of Handicapped Children be encouraged to provide special clinics in both rheumatic fever and cerebral palsy on a limited demonstration basis, utilizing "teams" of specialists, and with the cooperation and support of interested voluntary health agencies. If such a program is provided it is recommended that cases be studied only upon direct referral and, *whenever possible, that the family physician attend the clinic to go over the case with the specialists provided as consultants.* Only in this manner can the consultation service be of maximum value.

DIVISION ON GERIATRICS

J. A. Schindler, chairman; Owen Otto; M. J. Musser; A. M. Hutter; M. T. Morrison; R. H. Quade

This division has oriented itself in the field of its responsibility and secured some background as to what the various state agencies are doing in relation to care of the aged. At the first meeting of this division, representatives from the Department of Public Welfare and the State Board of Health were in attendance and provided a great deal of material for consideration of the division members. Also, aware of a survey on needs for the aged being carried on by the Community Welfare Council of Madison, representatives of this project were invited to acquaint the division members with work of significance being carried on through private welfare agencies.

It is apparent that there is need for official expressions by physicians on various matters pertaining to the care of the aged. The Public Welfare officials reported on the construction of new facilities in a number of counties and commented on the need

for guidance on many matters of direct concern to the medical profession. Such matters were those related to the selection of sites in relation to medical service, basic nutritional needs of the aged, medical authority within facilities provided for the care of the aged, and some advice on medication and its relationship to the economic problems of this special class of patients. The State Board of Health outlined the opportunities for use of the Division on Geriatrics as an advisory committee in the formulation of standards for the operation of special facilities for the aged. The discussion clearly indicated the need for medical guidance to county societies and other groups immediately concerned with these problems.

The division will proceed with the preparation of a guide which can be used by county medical societies and other groups immediately concerned with the development of facilities for the aged, providing recommendations of a medical character. The preparation of such a guide will be accomplished through the cooperation of state departments and other groups directly concerned with the administration of programs related to the aged.

* * *

A second important area is public information on health matters, with particular reference to problems of the aging population. Public forum meetings in other states have been reviewed and some discussion directed to the development of a special institute at the University of Wisconsin, touching on medical, social, and economic problems of the aged. It was felt that both types of programs were worthy of ultimate development, but that the implementation of these programs properly rested within the work of the Council on Medical Service. The Council should be requested to consider the possible development of both public forums and a state-wide institute on problems of the aged, with a further recommendation that the voluntary health agencies, the University of Wisconsin Extension Division, and other groups be consulted on a cooperative development of such programs, with proper financial support from agencies prepared to assist.

* * *

While these two specific matters have suggested Commission action, the division is aware of the growing concern of both society and the medical profession with problems of the aged. The division is impressed that more positive leadership on the part of the medical profession is needed to see that proper medical standards for the care of the aged are maintained and at the same time that the medical profession recognizes its responsibilities in keeping public welfare costs as low as possible with the resulting extension of services to the greatest number of persons. The anticipated growth of the aging population is one which demands the best thinking of both the medical profession and those charged with the responsibility of expending public funds. It is obvious that a closer working relationship is needed, both on a state and a county level. While the medical profession must maintain basic standards of care, there must also be recognition of the fact that society cannot support welfare programs on a luxury basis.

DIVISION ON MATERNAL AND CHILD WELFARE

R. F. Purtell, chairman; Amy L. Hunter; G. S. Kilkenny; A. H. Stahmer; J. D. Wilkinson; T. V. Geppert; F. G. Johnson, Jr.; D. D. Wilson; E. A. Birge

Maternal Mortality Study

A most significant project undertaken this past year has been the initiation of the Maternal Mortality Study as approved by the 1952 House of Delegates.

The project was designed to provide objective case analysis of maternal deaths with complete anonymity for family, physician, hospital, and community concerned. It is already apparent that the study will provide valuable material for hospital staff study and for planning postgraduate education. More than 40 cases have been studied to date, and the committee has had exceptional cooperation from both the physicians and hospitals contacted and from the physicians serving as interviewers.

There has been one change in procedure from that outlined to the House of Delegates in the October 1952 report. Certificate data (unidentifiable) is first reviewed by an obstetrician to screen out those cases where data to be gained would be so negligible as to make the time and expense of a personal interview impractical, e.g., motor vehicle fatalities involving expectant mothers. On such cases the obstetrician obtains, through correspondence, any limited data that may be needed on an individual basis.

While it is too early to give a full report of the work of the study committee, it has been suggested that the chairman present a verbal progress report to the House of Delegates at the time this report is before it so that delegates may be fully informed as to the purpose and findings of this scientific study. A detailed manual of procedures can also be obtained for review by any member of the House upon request.

Fetal Neonatal Deaths

The committee has reviewed with interest certain significant variations in the combined loss of life in the fetal and neonatal period in Wisconsin counties and hospitals.

Combined rates for counties with 1,000 or more births ranged from 14.7 to 43.4 and for comparable hospitals, 22.1 to 45.0. Although one cannot place too much emphasis on a single year's experience with less than 1,000 births, the combined rates for counties with 500–999 births ranged from 19.7 to 53.3, with comparable hospitals 18.6 to 71.5.

The committee re-emphasizes that the primary opportunity for improving services is for each hos-

TABLE 1—RECORDED COUNTY AND HOSPITAL DATA—1952

Counties with 1,000 or More Recorded Live Births	Live Births	Neonatal Deaths	Fetal Deaths	Combined Total	Combined Rate per 1,000 Live Births
Brown	3,811	69	76	145	38.0
Chippewa	1,333	31	23	54	40.5
Dane	4,869	92	46	138	28.3
Dodge	1,228	6	12	18	14.7
Douglas	1,013	19	25	44	43.4
Eau Claire	1,743	33	14	47	27.0
Fond du Lac	1,975	19	28	47	23.8
Jefferson	1,353	28	23	51	37.7
Kenosha	1,938	40	32	72	37.2
La Crosse	2,434	52	49	101	41.5
Manitowoc	1,640	25	17	42	25.6
Marathon	1,887	35	15	50	26.5
Milwaukee	23,611	463	373	836	35.4
Monroe	1,153	26	17	43	37.3
Outagamie	2,827	47	38	85	30.1
Racine	3,197	54	44	98	30.7
Rock	2,553	60	35	95	37.2
Sheboygan	2,204	31	31	62	28.1
Waukesha	1,375	19	25	44	32.0
Winnebago	2,353	43	46	89	37.8
Wood	2,153	49	28	77	35.8
Counties (21) 1,000+births	66,650	1,241	997	2,238	33.6
Counties (21) 500-999 births	15,492	279	206	485	31.3
Counties (29) Under 500 births	6,844	102	94	196	28.6
STATE TOTAL	88,986	1,622	1,297	2,919	32.8
Hospitals (excl. Milwaukee Co.) 1,000+births (18)	25,583	435	381	816	31.9
500-999 births (24)	17,483	321	217	538	30.8
Under 500 births (103)	21,109	359	288	647	30.7
Hospitals (Milwaukee County) 1,000+births (9)	20,323	357	291	648	31.9
500-999 births (2)	1,512	48	32	80	52.9
Under 500 births (11)	1,596	50	37	87	54.5
Home, other and maternity home	1,380	52	51	103	74.6

pital staff to have some very definite plan to study its own experience with fetal and neonatal deaths just as many are now doing with maternal deaths.

Pathology studies in various parts of the country have shown that careful postmortem examinations on newborn infants, who do not survive, have revealed definite causes of death, especially when combined with a careful review of the maternal history during pregnancy and delivery. In the hospitals with pathologists trained in special conditions of the newborn, such vague causes as "prematurity," "atelectasis," and "diseases peculiar to infancy" have been replaced by more definite causes of death. As causes of death are known, procedures can be instituted for their control. Even in fetuses after 20 weeks, careful postmortems by skilled pathologists have revealed factors responsible for death in as high as 80 per cent of the cases.

It is the opinion of the Division on Maternal and Child Welfare that efforts should be made to encourage the American Medical Association, through its Council on Medical Education and Hospitals, to revise its current rules for accreditation of hospitals approved for intern training so that more attention will be directed to fetal and neonatal deaths. It is suggested that the present regulations be changed to provide for a supplemental requirement of obstetric divisions within such teaching hospitals to secure a specified percentage of autopsies of the newborn, so as to secure more knowledge as to causes of death and to stimulate hospital staff attention to possible salvage of life in this group of patients.

It is further suggested that the Wisconsin delegates to the American Medical Association be requested to introduce an appropriate resolution in the December, 1953, session of the American Medical Association so that this objective can be attained.

TABLE 2—NEONATAL AND FETAL DEATHS BY CAUSE

(Wisconsin Resident Figures—1952)

	Neonatal		Fetal	
	No.	%	No.	%
Accidents and violence	8	0.5	18	1.4
Conditions of Mother:				
Birth injuries (Except cerebral and spinal) including cord and placental complications, malposition, disproportion, etc.	452	28.1	523	41.3
Diabetes	10	0.6	21	1.7
Disease, acute			15	1.2
Disease, chronic			17	1.3
Premature delivery	380	23.7	*	
Toxemia (excluding diabetes)	42	2.6	104	8.2
Conditions of Infant:				
Atelectasis and asphyxia	171	10.6	*	
Birth injury, cerebral or spinal	77	4.8	3	0.2
Congenital malformation	266	16.6	113	8.9
Erythroblastosis and Rh	57	3.5	83	6.6
Hemorrhage	14	0.9	12	0.9
Infections				
Diarrhea and enteritis	13	0.8		
Pneumonia	46	2.9	**	
Other	8	0.5	**	
Miscellaneous	17	1.1	21	1.7
Ill defined	42	2.6	98	7.7
Unknown	3	0.2	239	18.9
TOTAL	1,606	100.0%	1,267	100.0%

*Included under "ill defined."
**Included under "miscellaneous."

Prematures

The ratio of recorded premature births in 1952 remained approximately the same as 1951, 6.4 per cent of total live births. With 88,986 babies born alive in Wisconsin, 5,658 were premature, of which approximately 20 per cent—1,088, died in the first month of life. Therefore, the division wishes to reemphasize the need for physicians to assume full responsibility for directing the care of these babies, as well as to encourage Wisconsin hospitals to take advantage of opportunities for training their nurses in premature care. With adequate facilities, nursing care, and medical supervision, more premature infants can survive.

A word of caution was given about equipment. Incubators in which a high oxygen and humidity content can be maintained are important in saving the smaller prematures, but they cannot replace con-

tinuous observation and nursing care. Physicians and hospitals also need to consider carefully the potentialities and limitations of equipment on the market for care of premature infants.

There continues to be a need to use an ophthalmoscope routinely for small premature infants at regular periods from early in life if retrolental fibroplasia is to be recognized. Other special problems related to prematurity must also be looked for and promptly treated. The emotional problems to the family, because of high cost and the long period of care away from home, need consideration and cooperative planning.

Above all, the need continues for making an increased effort to find factors which are in part responsible for the interruptions of pregnancy before term. This varies in Wisconsin counties from 3.4 to 8.3 per cent of live births.

Certificate Data

The State Board of Health has been combining birth and death data on every infant dying in the first year of life. A striking fact is that physicians often fail to enter on the death certificate complications of pregnancy or labor which may have been the direct cause of the infant death. For two years the policy has been to use combined birth and death data in coding deaths on infants dying soon after birth, provided the same physician files both certificates. This has helped to reduce the very large group of deaths previously coded to prematurity and atelectasis, which are considered nonspecific causes.

The division also discussed the need for providing space on the lower portion of birth certificates for the physician to designate type of anesthesia and analgesia used since this would provide mass data on state practices and a means of measuring the trend toward "natural childbirth" in Wisconsin.

Definitions and Legislation

The division endorsed the international definitions of live birth and fetal deaths. It approved the State Board of Health recommendation for legislative action to substitute "fetal death" for "stillbirth" where it appeared in the statutes.

It was the opinion of the division that no action be taken at this time to require that fetal death certificates be filed on all products of conception since insufficient additional data would be obtained. The statutes require reporting only when a fetus had reached 20 weeks of gestation (4½ months).

The division agreed with the concept that individuals do not need copies of fetal death certificates; and there is, therefore, no need that they be retained permanently as state vital statistics records. In the recent legislative session Section 69.34 (3) was amended to authorize the state registrar and city health officers to destroy all fetal death certificates after a period of three years.

Obstetric Hospital Beds

Some Wisconsin hospitals have suggested that the rules restricting the use of obstetric beds be modified in order that, with proper safeguards of isolation and selection, these beds might be used for other patients. The division membership unanimously opposed any modification of rules in this respect and re-emphasizes that any deviation opens up avenues for possible infection which cannot be condoned in good medical practice. All physicians concerned with policies of hospital care are urged to see that hospital beds for obstetric patients are used only for obstetric patients.

Recommendations

1. Continued cooperation be given the Maternal Mortality Study Committee in its undertaking to assemble meaningful data for teaching purposes, and local hospital staffs and medical societies be encouraged to make use of members of the study committee for group discussions on the purpose and findings of the study.

2. Hospital staffs be encouraged to devote at least one meeting per year to a detailed analysis of maternal and infant deaths, and to undertake pilot studies of their fetal-neonatal experience.

3. The State Medical Society, through its House of Delegates, send a letter to Dr. H. G. Weiskotten, chairman of the A.M.A. Council on Medical Education and Hospitals, Skaneateles, New York, to promote postmortems on the fetus of 20 weeks or over. In addition, it is recommended that the Wisconsin delegates to the American Medical Association be requested to introduce a resolution to obtain this objective.

4. A pathologist be made a permanent member of the Division of Maternal and Child Welfare to round out its representative membership and its competence in promoting efforts directed to providing pathologists greater experience in the difficult field of fetal and neonatal postmortems, and to help medical staffs in interpreting pathological findings.

5. Physicians be urged to assume greater responsibility for care of the premature infant, for selection of equipment to be used, and for encouraging training in premature care for at least one member of the hospital nursing staff. Hospital staffs be encouraged to devote at least one meeting per year to special problems relating to the care of the premature.

6. Physicians be encouraged to use greater care in completing birth and death certificates so that maximum information is available for study, and to cooperate in providing the additional information on types of analgesia and anesthesia.

7. Hospital administrators and medical staffs be notified that the Division on Maternal and Child Welfare is opposed to any modification of the present ruling that obstetrical beds be restricted to obstetrical patients.

DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. Schwade, chairman; A. A. Lorenz; K. M. Keane; W. J. Urben; J. T. Petersik; H. H. Reese; Chester Wade; Horace K. Tenney, III

This division has initiated several important projects through subcommittees.

Basic problems have been discussed this past year and specific recommendations made. One concerns itself with key personnel in the field of psychiatry and the detachment of such personnel from state service to go into military service. It was the consensus that every effort should be made to have such individuals declared essential in order to maintain adequate medical supervision for the mental health programs of the state.

The division is conscious of the fact that all institutional programs are hampered because medical personnel is lacking. The problems at both Winnebago and Mendota are acute, and lack of trained personnel has retarded further development of therapy programs.

Special attention was directed to the need for more intensified examinations in county mental institutions in reference to tuberculosis and the provision of proper isolation facilities. The division has been informed that a cooperative study of this problem is being carried on under the direction of the State Board of Health and the Department of Public Welfare. A meeting has been held with the State Department of Public Welfare and Doctor Osborn. All physicians, who are in any way connected with the medical supervision of county mental institutions, are urged to cooperate with this study so that proper standards of examinations and isolation of infectious cases can be employed.

The division is aware of need for more supervision of county mental health programs through services extended through the Division on Mental Hygiene, but again lack of funds to secure adequately trained personnel is a problem which must be met before anything further can be accomplished. In many cases funds are set aside for the hiring of such personnel, but the pay scale is still so far below the income of psychiatrists in private practice and in the Veterans Administration that such positions are not being filled.

The executive office of the state is in strong support of a positive program in mental health; but even with this important support, the program is sorely lacking because of inadequately trained personnel. Until such time as the Division on Mental Hygiene is able to secure more trained personnel, all proposals to have county institutions meet minimum standards agreed upon by the State Medical Society and the Superintendents Association are of little avail.

The division notes with pleasure that two important projects in the mental health program in Wisconsin are either underway or have been given the "green light" in future planning. The Diagnostic Center is under construction in Madison and will offer an opportunity to have all committed children studied intensively prior to placement in a state institution. This will give the medical profession, as well as the Board of Public Welfare, an avenue through which tests of a scientific nature can be employed to secure proper evaluation of all children who are in serious difficulty, and whose commitment is suggested by court action.

The second important project is that of establishing a Central Colony on the grounds of Mendota State Hospital where children of low mentality can be studied and best methods of treatment employed. The location of this Colony, in close proximity to the University of Wisconsin Medical School, offers great opportunities for improved knowledge in this field and an opportunity for research which should result in better care and therapy for Wisconsin children.

As is known to the House, legislation pertaining to the marriage of epileptics was passed in the 1953 session of the legislature. It is felt by the division that this is one important step in recognizing the special character of this medical problem and that it has properly detached the epileptic from the statutory classification with morons, idiots, and imbeciles. Subsequent legislation, not introduced at the request of the State Medical Society, was finally passed legalizing epileptic marriages preceding the revision just outlined. Undoubtedly this measure will come before the judiciary to determine its legality.

The following reports of subcommittees will inform the House as to special studies which have been carried on under the direction of the Division on Nervous and Mental Diseases during the past year.

A. SUBCOMMITTEE ON COMMITMENT LAWS

Keith M. Keane, chairman; R. A. Jefferson; Michael Kasak; Owen C. Clark; J. F. Klepfer; J. T. Petersik; W. J. Urben; E. D. Schwade, ex officio

Commitment procedures have many medical aspects, and the Division on Nervous and Mental Diseases has appointed a special committee to study the existing statutes and to make recommendations as to changes which will make the medical aspects of court examinations and apprehension of persons suffering from emotional disturbances, with particular reference to emergency commitments, more effective and in keeping with sound medical practices.

To date this committee has met several times and is coordinating its studies with those of other agencies and groups interested in the same problems. By request of the subcommittee, a special committee of the County Judges Association has been appointed to work on the same problem, and joint meetings with this group have already been held. Likewise, the Department of Public Welfare and the physicians most closely associated with the Northern and Southern Colonies have been consulted as to portions of the laws which most directly affect these particular groups.

It is anticipated that during the ensuing year a complete report of this committee will be made to the Division on Nervous and Mental Diseases, and through the division to the Commission, the Council, and the Committee on Public Policy for development of specific legislation to be introduced in the 1955 session of the legislature.

B. SUBCOMMITTEE ON EMOTIONALLY DISTURBED CHILD

M. G. Peterman, chairman; Sara Geiger; Owen Otto; John Gonce, Jr.; Eugenia Cameron; Mabel Masten; Robert O'Connor; A. A. Lorenz

A significant lack of facilities for the care and treatment of the emotionally disturbed child has caused the Division on Nervous and Mental Diseases to appoint a special committee to study this problem. To date the committee has confined its efforts to a review of those few facilities which do exist, and to see what might be done to encourage the development of new facilities.

The construction of the Diagnostic Center in Madison will offer a rich opportunity for research on basic problems of emotional disturbance in children who are committed; but even if this is able to function to full capacity (which is dependent upon the securing of trained personnel), the handling of a full case load will be just "scratching the surface." However, it will be an important link in the entire program which must be developed if the problems of children, with resulting delinquency or emotional breakdown, are to be met in an adequate manner.

The further development of the Child Guidance Centers is, of course, an important need but can only be accomplished by creating a community demand for such a service, and of even greater importance, providing a pool of trained psychiatrists from which leadership can be derived. The Guidance Centers, which have been established under the State Board of Health, have functioned effectively in those areas where psychiatric service is available; but in many areas where a community has expressed a desire for this service, there is lack of personnel to bring the project to fruition. As long as there is a lack of psychiatric workers, there is little hope that all communities, needing and desiring the services of Guidance Centers, can be served; but even the existing Centers can expand their functions if physicians outside of the community become better acquainted with their services. It is suggested that those Centers which can expand their services make such facts known to physicians in adjacent areas.

In studying the needs of children with emotional disturbances the committee has noted with satisfaction that the Division of Children and Youth is actively supporting a state-wide study of this problem. Largely through the initiative of the Division of Children and Youth the 1953 legislature has approved a study of this character to be made under the direction of the Legislative Council, and undoubtedly the State Medical Society will be called upon to assist with the work of this group. It is anticipated that this study will not only concern itself with institutional care, but also with proper use and supervision of foster homes for disturbed children, and what types of therapy can be conducted in Guidance Centers or through hospitals on an outpatient basis.

Even at this early stage of its efforts the Subcommittee on the Disturbed Child is impressed with several things: (1) existing facilities are very inadequate and often are not as effective as desirable, due to lack of trained personnel, and (2) many patients which are institutionalized, could be treated outside of an institution if local facilities could be organized to meet this basic community need. Within the committee itself there is division of thinking as to what type of patients should be institutionalized and which should receive therapy through outside sources, which again emphasizes the need for such a facility as the Diagnostic Center to set standards of selection and also to provide a basic guide for evaluation of cases through other agencies. A study has been made in Milwaukee to be used as a guidepost in consideration of development of a demonstration unit there.

While this report is necessarily incomplete and in a sense places stress upon inadequacies rather than existing facilities, it is hoped that within a year this committee, in cooperation with other groups concerned with the same basic problem, will be able to present a report which will have substance in the form of specific recommendations and at least a partial blueprint for action. Until then, it is the hope of the subcommittee that delegates will urge their county society members to become better acquainted with existing facilities, such as the Colonies, Sparta, Wisconsin General Hospital, and the 17 child guidance centers.

C. SUBCOMMITTEE ON PSYCHIATRIC RESIDENCIES

Chester Wade, chairman; H. H. Reese; Horace K. Tenney, III; Keith Keane; William Bleckwenn; Leslie Osborn; W. S. Middleton; E. D. Schwade, ex officio

This division stresses the need for more trained workers in the field of psychiatry. A special committee has been appointed to see what could be done in this respect through the University of Wisconsin Medical School.

Upon inquiry to the office of the dean of the University of Wisconsin Medical School, it was learned that the blueprint for such a training program has been set up, but that there has been no request for the terms of the grant. The program provides for a three-year fellowship in neurology and psychiatry, with training in neuroanatomy, neurophysiology, neuropathology, medical psychology, psychopathology, and sufficient neurology for the psychiatric trainees and psychiatry and neurosurgery for the neurological trainees. Treatment includes electroshock and insulin shock therapies, as well as psychosurgery, intensive psychotherapy and interviewing at the in-and-out patient levels, as well as six months of child psychiatry.

Since July 1, 1952, this program has been integrated into the training programs of the State Department of Public Welfare and the State Board of Health, to combine all institutions under these two state agencies and to be used for a portion of the training program.

It is regrettable that such a fine program has not as yet been in demand, as it would provide a good stipend while in training, and would add to the number of trained persons available for many psychiatric services in Wisconsin now in need of trained personnel.

It is hoped that physicians will keep this program in mind if they know of young people whose interests lie in the fields of neurology and psychiatry. Directing them into this training program would be one way in which the lack of psychiatric services could be met, and while in training they could be of immeasurable help in the state institutions now harassed with a dearth of persons with psychiatric training.

DIVISION ON PUBLIC ASSISTANCE

H. W. Carey, chairman; E. W. Schacht; W. K. Simmons; C. M. Carney; C. A. Olson; L. F. Morneau

While the State Medical Society at staff level and through occasional committees has been consulted on matters relating to poor relief, categorical aids, and general administrative problems in the public assistance field, the development of the Commission and its Division on Public Assistance is the first occasion in recent years to formalize physician activity in the field.

Thus, the burden of division activity in 1953 has been to acquaint itself with public assistance programs and their problems.

The Division on Public Assistance of the Department of Public Welfare reviewed its problems and indicated that the greatest administrative difficulty arises from the variations between counties as to costs and the reasons for the differences; as to restrictions; and policies as to method of authorization for care and the extent of it. That department has the whole field under study in an effort to bring about more uniformity on a state-wide basis, possibly through state-wide schedules or administration or a maximum on a per capita basis.

It has been recommended by the division and approved by the Commission that in cooperation with the Public Assistance Division of the Department of Public Welfare a comparative study be made of county fee schedules and policies as to authorization procedures and limitations, revisions of schedules, et cetera. That study is under way at the present time, with particular emphasis upon the "frequency" with which surgical and other procedures are encountered. This will vary from insurance experience and is of obvious importance in an effective study.

The division has also reviewed administrative and other problems involved in institutional care of public patients with particular reference to the place of the physician in the operation of the county institution, the extent of his authority in medical matters, and his part in determination of policies and the need for medical guidance in preparation of adequate and realistic standards of care.

It is recommended that efforts be made to have the county medical society offer cooperation to the medical director of each county institution for the appointment of an advisory committee of physicians. Such committee would review major matters of medical policy established by the medical director, and at the request of the lay director may be consulted as to any matter of dispute.

Included as other recommended projects in the current program of the Division on Public Assistance are efforts to improve liaison between county medical societies and welfare units and the investigation of the "pool plan" and its experience in directing welfare programs.

DIVISION ON REHABILITATION

R. G. Piaskoski, chairman; P. J. Collopy; E. P. Roemer; J. G. Beck; C. C. Gascoigne

Prior to the organization of this division, the State Board of Vocational and Adult Education occasionally was advised by a medical advisory committee which has been relatively inactive in the last few years. Rehabilitation efforts conducted through other state agencies have not been reviewed through an official body of the State Medical Society as far as is known. Thus, the important effort of this division of the Commission has been to assemble the important data and policies in planning for the future. Some of the more important matters follow.

Revised Fee Schedule

It has been felt by those administering funds for rehabilitation that the fee schedule adopted several years ago, based on the fee schedule of the Wisconsin Veterans Medical Service Agency, is unrealistic in many cases. For this reason the division authorized a study be undertaken of items or procedures on the present schedule which are causing concern to the Rehabilitation Division and to physicians.

The director of medical service in the state department has submitted a schedule of fees on which he has designated the procedures with which the Rehabilitation Department encountered the most difficulty. A study is being conducted on a comparative basis, using the present Wisconsin Veterans Medical Service Agency fee schedule items and the prepaid plan fee schedule under the "A" program. When

this study is completed, the special study committee will report its findings with recommendations.

As a further action, the division recommends that a special fee committee be appointed within the Commission to study present schedules and draw up a revised fee schedule for recommended adoption by and application to all state agencies.

Division to Serve as Advisory Committee to State Department

The Rehabilitation Department of the Board of Vocational and Adult Education is required to have a medical advisory committee. It was suggested that the Division on Rehabilitation of the Commission on State Departments serve as this medical advisory committee rather than make appointments and reappointments to a second similar group. Therefore, it was the division's recommendation that it be accepted as the medical advisory committee to the state agency, without change in its present membership.

On July 1, 1953, Mr. C. L. Greiber, director of the Vocational and Adult Education Board, advised the Medical Society as follows:

"This is to inform you that at the last meeting of the State Board of Vocational and Adult Education, the State Board abolished the present Professional (Medical) Advisory Committee for Vocational Rehabilitation, and accepted the Division on Rehabilitation of the State Medical Society as the State Professional (Medical) Advisory Committee for Vocational Rehabilitation, effective as of July 1, 1953.

"We will call upon the Division for advice regarding medical and similar problems in our program of Vocational Rehabilitation of handicapped persons."

Recommendations

1. The division recommends as one of its major projects, the education of physicians as to:
   (a) Responsibility of the physician for rehabilitation of his patient.
   (b) Facilities and services for rehabilitation available to the physicians of Wisconsin.
   (c) Procedures for utilization of such facilities and services, public as well as private.
2. Education of the public regarding rehabilitation.
3. Interest has also been expressed in meeting from time to time with regional medical advisors of the Rehabilitation Division of the State Board of Vocational and Adult Education.

DIVISION ON SCHOOL HEALTH

E. H. Pawsat, chairman; A. C. Edwards; F. J. Mellencamp; A. H. Heidner; G. M. Shinners; W. R. Manz

This division has met to advise with representatives of the State Board of Health and the Department of Public Instruction as to ways in which school health programs can be conducted more effectively.

The success of the 1952 "Conference on Physicians and Schools" has prompted the Division on School Health to recommend the development of regional conferences during 1954, following the national conference sponsored by the American Medical Association to be held in October. It was the consensus that periodic re-evaluation of school health practices would be desirable, and when possible, such conferences should be developed on a "grass roots" basis. Therefore, the division has recommended the planning of several regional conferences next spring, with sites to be the State Colleges whenever possible.

To provide a realistic basis for proposed conferences, the division, in cooperation with the Wisconsin Cooperative School Health Council, is making a survey of school health programs, supplementing the survey conducted this past year by the Division on Tuberculosis and Chest Diseases as to school employee examinations.

Increasing attention is being directed to competitive sports on the elementary and junior high school levels. Various school groups are concerning themselves with this problem, and the Division on School Health is interested in the conclusions to be reached. It has been the consensus to date that competitive sports for youngsters below the high school level are not bad *per se*, and with proper supervision, grading as to age and weight, and limited schedules of competition, might well serve a need for a number of children with unusual athletic abilities. But the division has agreed with those who condemn programs which place undue stress upon the competitors by way of newspaper publicity, competition before large adult groups, and competition outside of the community itself. While the policies of schools on this problem have not been crystallized, the Division on School Health will accept the opportunity of expressing its views, following proper authorization from the Council and the House of Delegates.

While the insurance features of the Wisconsin Interscholastic Athletic Association are of direct concern to the Commission on Prepaid Plans, there are other aspects of the program which should receive periodic medical review. The establishment of medical regulations in respect to renewed competition following injury is just one area of the program which needs medical guidance. It is suggested by the division that it make itself available to meet with the executive secretary of the Wisconsin Interscholastic Athletic Association at periodic intervals to review the medical regulations of the program and serve in an advisory capacity, if such would be desired.

Recommendations

1. County medical societies interest themselves in the proposed regional conferences and actively participate in the programs.
2. The Division on School Health be authorized to meet with school groups to help formulate policies for the conduct of competitive sports on the elementary and junior high school levels, with the responsibility of clearing any suggested policies with the Council or the House of Delegates before being publicly announced as approved by the State Medical Society of Wisconsin.

3. The Division on School Health make itself available to the Wisconsin Interscholastic Athletic Association to serve in an advisory capacity in reference to medical regulations of the program.

DIVISION ON TUBERCULOSIS AND CHEST DISEASES

J. D. Steele, chairman; L. W. Moody; H. A. Anderson; C. M. Yoran; G. C. Owen

Following the basic policies of its predecessor committee, the division has served in an advisory capacity to the State Board of Health and also has advised with the medical director of the Wisconsin Anti-Tuberculosis Association in reference to policies governing services to sanatoria, hospitals, and medical groups.

During this past year some special problems have come before this division. In addition, it has sought to secure more information on the effectiveness of programs carried on during the course of years.

Consultation Services

For many years the Wisconsin Anti-Tuberculosis Association has provided consultation service to county sanatoria, to a point where the service has gone far beyond the demonstration stage which prompted its original adoption. The Board of Directors of the W.A.T.A. have felt that their programs of professional and public service should be directed into new channels, and modifications of the consultation service have been suggested. These modified policies were reviewed by the Division on Tuberculosis and Chest Diseases, approved, and publicized through a statement published in the *Wisconsin Medical Journal* of April 1953. It is hoped that those physicians immediately concerned will work with W.A.T.A. in a gradual shift to conform with the established policies of consultation as announced this past year.

The consultation service of the State Board of Health, in cooperation with the staff of Wisconsin General Hospital, has offered avenues for professional education which are being used to an increasing extent by medical directors of county sanatoria. Those concerned with this program are to be commended upon the effectiveness of the service. Those members who are most closely associated with the medical supervision of county sanatoria are urged to make use of this service to the greatest possible extent. (Consultation service of the State Board of Health was discontinued as of July 1, 1953. The reason given for this by the Board of Health is that federal funds are no longer available for support of this service.)

Teacher Examinations

Both the State Board of Health and W.A.T.A. report more use of mobile units at the annual convention of the Wisconsin Education Association by teachers attending, but it was the feeling of the division that more emphasis should be made to expand the application of the Wisconsin statutes permitting the use of school funds for the examination of teachers and other school employees as a condition of employment. On the basis of this recommendation a survey has been made of all Wisconsin schools to determine the extent of coverage and whether the requirements are such that compulsory legislation is not needed. It was agreed that if the objectives of the program could be attained by local school board requirement and avoidance of a state compulsory regulation, such an approach would be desirable. The completed survey indicates a steady increase in the number of schools which require initial examinations for employment, including x-rays of the chest and periodic re-examinations to give proof of freedom from tuberculosis. The complete findings will be published in the *Wisconsin Medical Journal.* Efforts will be made to have all schools adopt more stringent policies as a means of protecting students and other school employees from infectious contacts. When these findings are published the division will request cooperation of physicians and county societies in developing programs in those areas where examination programs are inadequate or lacking.

Chest Films Supplied Physicians

Attention has been directed to the possible service of the State Board of Health and other agencies which take chest films, of making copies of films available to physicians when there is need for more detailed study of the patient. Recommendations have been made to the State Board of Health that enlargements of films be made available to physicians upon request, and that all agencies providing film service give other agencies their schedules of surveys so that proper identification of films can be secured. The service of the State Board of Health was announced in the July issue of the *Wisconsin Medical Journal.*

Legislation

The previous Committee on Tuberculosis and Chest Diseases had recommended a revision of the Wisconsin Statutes relating to free care in outpatient departments of sanatoria, substituting the words "or suspected tuberculosis" for the existing phrase "and other pulmonary diseases," as it was felt that the wording of the statutes might be interpreted to mean that persons, suffering from allergies, pneumonia, and other ills, not in any way associated with tuberculosis, might claim service under the free care law. Such a revision was endorsed by the Committee on Public Policy, was accepted at the legislative hearing without opposition and with desired support, but failed to emerge from the rush of legislative action in the closing days of the 1953 session. Because it was generally accepted that the suggested rephrasing would be desirable, it is recommended that this legislation be reintroduced in the 1955 session of the legislature and given sufficient priority to secure its enactment.

Physician Follow-Through of Suspected Cases

The State Board of Health has reported that there is need for more intensive follow-up of suspected cases of tuberculosis by the family physician who receives only the report of abnormal findings. It was suggested that the State Board of Health should prepare some interpretive material which would be sent with the patient report, to prompt the doctor to assist with further and more intensified study of suspected tuberculosis in the care of his patients. It is hoped that such material can be made available for use this coming year, either through the State Board of Health or W.A.T.A., in cooperation with the National Tuberculosis Association.

Coverage of Services in Health Insurance Programs

Considerable discussion has been directed by division members to the adequacy or inadequacy of current health insurance programs for services rendered to policyholders when such services are not covered by terms of the free care law. It was the consensus to meet with representatives of the Blue Shield and Blue Cross plans to review the extent of care now available under the programs, as related to those suffering from tuberculosis, and if benefits could be expanded to meet specific needs which seem consistent with the basic principles and goals of the Blue Shield-Blue Cross programs, that such additional coverage be provided.

Recommendations

1. Delegates and members closely associated with the affairs of county sanatoria cooperate with the W.A.T.A. and the State Board of Health on the consultation services available under terms of the new, revised policies of W.A.T.A.

2. When the survey is completed on school personnel, and certain areas of inadequacy of the examination program are revealed, local physicians and county societies assist by calling attention to the desirability of an approved examination service, and cooperate with school authorities to see that the service can be rendered with adequate reimbursement to the physician and no undue hardship upon the school board or the teacher who pays for the service.

3. The State Board of Health accept the recommendation of the Division on Tuberculosis and Chest Diseases in the development of interpretive material which would be sent the family physician on all cases of suspected tuberculosis and which would enlist his cooperation in a more effective follow-through of the case being reported.

4. Legislation, similar to that introduced in the 1953 session of the legislature, be reintroduced in 1955 to clarify the sections of the statutes in 50.08 so as to avoid possible misinterpretation of the statutes as to conditions under which the services of the free care law can be applied.

5. The Blue Cross-Blue Shield programs be studied by representatives of the two plans and the Division on Tuberculosis and Chest Diseases to see if current benefits are adequate to meet the needs of policyholders who contract tuberculosis and receive services under terms of the free care law.

DIVISION ON VISUAL AND HEARING DEFECTS

T. L. Tolan, chairman; E. J. Zeiss; W. M. Nesbit; A. B. Schwartz; J. W. Doolittle

For the first time in a number of years problems relating to vision and hearing have been combined. This division has met with representatives of the Bureau of Handicapped Children and has reviewed in detail the programs being carried on by that agency. For clarity the report will concern itself with each field, separately:

I. Hearing

A. *General Status.* As outlined in previous reports to the House of Delegates the hearing program being carried out in Wisconsin schools is one of the best, if not *the* best, in the United States. With cooperation of the previous Committee on Hearing Defects, the Department of Public Instruction, through its Bureau of Handicapped Children, has set up a program of screening and selective "follow-through" regarded as a model for other states. The report presented to the division in February, 1953, covered the school year from September, 1951, to June, 1952, during which period 68,000 Wisconsin school children had been audiometrically screen-tested in 16 county and in 19 city programs. In accordance with a state-wide plan, approximately one-third of the counties are covered by screening programs each year, while in cities, where specialized personnel is available, the program is conducted on an annual basis.

Special attention has been directed to "follow-through" programs, so that the screening tests serve a practical purpose. Approximately 5 to 8 per cent of all persons screened are given rechecks, and then this number has dropped to about 1.5 to 3 per cent, who are then seen at otologic clinics, to which the parent and family physician are invited. A regrettably low percentage of family physicians attend the clinics; more physician consultation with the otologist would provide better home-town care.

Methods of financing were carefully reviewed by the division. It should be noted that even though the Bureau of Handicapped Children has some funds available for payment of appliances through federal grants, every effort is first made to have the expense met locally. The parent is urged to pay, when possible; if the parent can pay only part, this is encouraged; and other community resources (such as service club funds) are used; if neither the home nor the community can pay, there are limited funds available through the Bureau of Handicapped Children, and the report indicates that in the past year only some $1,000 was so used, upon request of public health nurses.

B. *Psycho-Galvanic Skin Testing.* To evaluate hearing function in very young children or those with handicaps which do not afford the usual avenues of communication between the tester and the person

being tested, a new type of skin testing has been employed at the University of Wisconsin with excellent results.

C. *Industrial Hearing Problems.* Increased attention has been directed to the matter of hearing loss due to industrial noise exposure, and several important compensation claims on the subject have been in Wisconsin courts. In the past session of the legislature a law was passed which included *traumatic* loss of hearing as a basis for compensation. To assist the physicians with full information on this subject and the responsibilities of physicians in providing proper records for employers, a series of special meetings on this subject were arranged in cooperation with the Wisconsin Council of Safety, the State Board of Health, and the Wisconsin Manufacturers Association. Two have been held, and the third will be held in Racine on October 14.

II. Vision

For years there has been need for a concise guide to be used by school authorities and physicians in establishing visual programs in Wisconsin schools. While some county medical societies have given valued assistance in the establishment and operation of such programs, in other areas the physicians have not assumed professional responsibility when such assistance was requested. In some of these areas other groups interested in vision have suggested programs in which the screening was rendered "free" by the very persons who were to render the service of critical vision evaluations. This has seemed improper to state personnel who have worked with the hearing programs, and it was partly to meet this need that a special guide was prepared by the Division on Hearing and Vision and distributed to all schools in the state. The county medical societies have been informed of this program and urged to provide professional guidance when requested by school authorities. It is hoped that this program can and will be put into practice in many Wisconsin communities during the ensuing year.

In July, 1952, the *Wisconsin Medical Journal* carried an insert on state services for the blind or those suffering with serious vision loss. On direction of this division, a second mailing, with an additional supply of report forms was directed to all physicians who limit their practice to eye, ear, nose, and throat. In this way it is hoped that many patients will be encouraged to seek assistance from state agencies before vision loss becomes so acute that the person has little will to become rehabilitated.

Recommendations

1. Physicians continue to support the hearing program through cooperation with those conducting the otologic clinics. When possible, it is desirable to have the family physician in attendance at the otologic clinic, especially where hearing loss is very great and psychic problems related to the disability are marked. County medical societies are urged to keep close supervision over all otologic clinics so that proper interpretation as to their functions can be made to the county society members.

2. Physicians, closely associated with industrial plants, provide proper medical supervision for any programs designed to screen employees, evaluate their hearing capacities, and provide re-examinations to detect serious hearing loss.

3. All county medical societies provide schools with proper medical guidance so that the basic principles outlined in the "School Vision Screening Program" approved by the Division on Hearing and Vision (as well as the Division on School Health) can be implemented in Wisconsin elementary and secondary schools.

COMMISSION ON STATE DEPARTMENTS

Conclusion

The preceding report represents many conferences and a total of 20 meetings through July. In 1954, the preliminary work of 1953 should be evidenced by established programs in the various fields. The Commission in particular desires to express its appreciation to officials of the State Board of Health, the State Board and the State Department of Public Welfare, the State Department of Public Instruction, and the State Board of Vocational and Adult Education for their invaluable, as well as willing, assistance.

COMMITTEE ON BLOOD BANKS

W. D. Stovall, chairman; T. J. Greenwalt; C. N. Neupert; Paul Mason

During this past year a very special problem has been handled by the Committee on Blood Banks—that of assisting the state health officer in establishing basic policies for the distribution of gamma globulin, used in the control and treatment of poliomyelitis. This special problem was assigned the committee by direction of the Council.

In setting policies for the state health officer the Committee on Blood Banks has been aware of the divergent thinking, on a national level, in reference to the most efficacious use of the limited supply of gamma globulin which would be available to Wisconsin. The basic procedures outlined by the National Health Resources Committee have been used as the foundation on which the Wisconsin program has been built. The plan of distribution and allocation was announced to the membership by way of a special bulletin, and proper press interpretation was sought through the agency of a special letter to all editors of Wisconsin papers, enlisting their support and correct interpretation of the program to the public. The response of both physicians and editors has been most commendable, and it is gratifying to note that the program has been carried on with little friction and misunderstanding. Procedures, which have been approved by the Council, have been set up for possible mass immunizations, if a localized epidemic should occur, with county societies assuming responsibilities of professional services required. What the future of the gamma globulin program

will be is impossible to predict, but this year's experience, both nationally and in Wisconsin, may provide at least a partial answer to its effectiveness as a control agency. The Committee on Blood Banks holds itself ready to serve the Council by continued efforts in this field, if so directed.

Blood Procurement Program

The Committee on Blood Banks has continued to function in an advisory capacity to the Badger Regional Blood Center in Madison, and to relate its activities to the services rendered in and around Milwaukee County by the Junior League Blood Center. Reports of both indicate great progress made in the procurement of blood, both for military and civilian use. The over-use of blood, noted in 1952, has seemingly been corrected, partially due to an excellent article published in the Wisconsin Medical Journal by a member of the committee.

A review of procurement policies has indicated a need to re-evaluate certain restrictive measures handed down by National Red Cross. It has been felt by the Committee on Blood Banks that rules heretofore employed as to restrictions placed on the use of donors, who had given birth to children within a year prior to offers of blood donations, and refusal of blood from those afflicted with certain types of allergy were most unrealistic and seriously curtailed the amount of blood which could be procured without hazard to the donors. Due to the efforts of the Committee on Blood Banks several of the national medical groups most immediately concerned with these problems have re-evaluated the standards of National Red Cross, and it is anticipated that certain current restrictions will be modified or removed, and local medical advisory committees will be given more latitude of judgment in reference to donor standards.

The director of the Badger Blood Center reports increasingly good cooperation on the part of local medical groups in providing medical supervision when the bloodmobile visits their locality. This type of local supervision is not only desirable as a means of keeping operating costs of the Blood Center down and costs of service to cooperating hospitals as low as possible, but also as good public relations on the part of the physicians in communities served by the procurement program.

Recommendations

1. The Committee on Blood Banks continue to serve in an advisory capacity to the Badger Blood Center, Madison, and make itself available to the Junior League Center in Milwaukee if it needs special help not provided by its local medical advisory committee.

2. The Committee on Blood Banks be authorized to represent the Council and the House of Delegates in further development of the gamma globulin program, and through the help of the State Board of Health to present a report of the program some time during 1954, so that future planning can be done on the basis of experience gained.

3. The principle of local medical supervision of blood procurement programs be re-affirmed, and all members of the State Medical Society be urged to provide such supervision at all times when blood is being procured through authorized agencies in their individual communities.

4. Any hospital or doctor, having a complaint against the blood bank program, make such complaints direct to the Committee on Blood Banks, which will serve as a review board and attempt to reach a satisfactory solution to the problem.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY OPERATING COMMITTEE

J. S. Supernaw, chairman; Maurice Hardgrove; J. L. Moffett; W. A. Fischer; Otto A. Dittmer

The State Medical Society of Wisconsin, through its Veterans Medical Service Agency, operates the program known as the Home-Town Care Program for Veterans. It has operated continuously since 1946 in cooperation with the Veterans Administration.

TOTAL VALUE OF BUSINESS WITH THE VETERANS ADMINISTRATION

	July 1, 1951 through June 30, 1952	July 1, 1952 through June 30, 1953
Total authorizations received from the Veterans Administration	$167,782.50	$171,268.18
Total authorizations cancelled	17,392.74	17,998.94
Unused authorities	25,208.97	26,198.54
Total cash paid to physicians	134,750.96	136,170.98
Total amount received from Veterans Administration for administrative expenses	22,041.03	19,210.91

The contract existing between the State Medical Society and the Veterans Administration is on a year-to-year basis, and it operates on a cost basis for administration.

The committee has had two meetings during this past fiscal year, and the Veterans Administration officials were invited to meet with the committee to discuss problem cases. Doctors from the Veterans Administration discussed the problem they have in approving authorizations for treatment when medical reports from the doctors do not adequately describe the need for the services and the services that are rendered. Doctor Sebastian, chief medical officer of the Veterans Administration Regional Office, produced case records that demonstrated an exact repetition of information under diagnosis and treatment of the same veteran month after month without any change. Doctor Sebastian requested cooperation of the Wisconsin medical profession in adequately filling out the prepared forms that describe the services and include the bill for services rendered.

Type of Care

Home-Town Care of the Veteran is limited, for all practical purposes, to home and office calls and labo-

ratory procedures. Only emergency cases of hospitalization are approved.

A study was made of the March invoices submitted to the Veterans Administration for payment. There were a total of 1,026 invoices. Seventy-two per cent of these were $10 and under; 19 per cent were from $10 to $20; 7 per cent, from $20 to $40; 2 per cent, over $40.

Fee Schedule

The surgical part of the fee schedule is used very little, because the Veterans Administration desires to have as much surgical work performed at the Veterans Administration hospitals as possible.

It has come to the committee's attention that some of the state agencies use the veteran's fee schedule, and the surgical part of this schedule is less than the "A" schedule of the prepaid plans of the State Medical Society. It has been suggested that the committee take this into consideration when discussing fee schedule problems with the Veterans Administration.

The following is a certified financial statement as of December 31, 1952:

WISCONSIN VETERANS MEDICAL SERVICE AGENCY
Madison, Wisconsin

CERTIFIED FINANCIAL STATEMENT
December 31, 1952

ASSETS		
Current Assets		
Cash in Bank—Administrative Fund	$4,868.67	
Cash in Bank—Medical Fund	4,928.11	
Petty Cash	10.00	
Medical Claims Filed with Veterans Administration	4,651.55	
Administrative Claims Filed with Veterans Administration	1,542.59	
Total Current Assets		$16,000.92
Fixed Assets		
Office Furniture and Fixtures	$2,434.17	
Less: Accumulated Depreciation	1,374.06	
Total Fixed Assets		1,060.11
Prepaid Expense		
Unexpired Insurance		18.63
TOTAL ASSETS		$17,079.66
LIABILITIES		
Current Liabilities		
Due Doctors on Claims Filed	$9,579.66	
TOTAL LIABILITIES		$ 9,579.66
ADVANCE FROM STATE MEDICAL SOCIETY OF WISCONSIN		
Balance of Cash Advance—December 31, 1952		$ 7,500.00

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, an agency of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period July 1, 1952 to December 31, 1952, and,

I hereby certify that, in my opinion, the above Financial Statement correctly represents the financial condition of the Agency on December 31, 1952, and the result of its operations for the period July 1, 1952 to December 31, 1952 in conformity with generally accepted accounting principles.

/s/ Donald E. Gill
Certified Public Accountant

Madison, Wisconsin
April 3, 1953

SUPPLEMENTARY REPORT OF THE COUNCIL

The supplementary report of the Council included the following, distributed to the House of Delegates in mimeographed form.

COMMITTEE ON CIVIL DEFENSE

M. J. Musser, Madison, chairman; E. P. Ludwig, Wausau; K. E. Lemmer, Madison; J. S. Wier, Fond du Lac; E. A. Bachhuber, Milwaukee

Doctor Musser, chairman, in presenting the following report, acknowledged the splendid support received from doctors throughout the state in the preparation of civil defense plans and emphasized that excellent relations exist with the State Board of Health and the office of the Civil Defense Director.

Interest in civil defense, both public and professional, fluctuates with the fortunes of the hot and cold war. Those who work with civil defense are faced with the unalterable fact that the freedom-loving American people have no relish for diverting a major portion of their daily lives to a long-term program of planning, organization, and training for what they consider is an essentially military operation. The people of America are not unaware of the tremendous serious consequences of sudden enemy attack. It is simply that they have an endless faith in the promises of peace, and failing that, a boundless courage that they have the physical strength and the material resources to recover and survive anything that might happen. While this attitude poses a nightmare for the militarist, it forms the basis for a sound and realistic approach to the gigantic problem of self-preservation in the event of disaster.

The medical aspects of civil defense planning in Wisconsin have their core in the establishment of 100 mobile medical teams outside of Milwaukee County, the primary target center. Each of the teams has 29 members, with physicians as the team captains and deputy captains. These teams are part of the official State of Wisconsin civil defense establishment. It should be understood, however, that the mobile medical teams may be considered part of the local civil defense establishment to the extent that, if a local disaster occurs, the state mobile teams of that locality may be used to provide the help that is needed.

The major effort of the Committee on Civil Defense in the past year has been directed at bringing the county medical society into the administrative structure of the state civil defense program. The lines of authority of the state civil defense program run directly from the state level to the city with respect to the agencies of government involved. This works well in fire, police, and similar services, but medicine is organized on a county basis; and, consequently, the committee has insisted that all civil defense activities within a given county should be channelled through the county medical society's civil defense committee.

The crux of the organizational problem in civil defense is personnel. It follows, therefore, that the county society should be responsible for making the assignments of professional personnel within the

medical society to work in civil defense and to hold these physicians responsible for progress. It has been a major accomplishment of the committee that the state civil defense officials have established a chain of command within the civil defense organization which runs from state civil defense director to area co-director to county medical society to mobile medical team captains. Two important patterns have emerged from this concept of civil defense organization:

(1) The state director of civil defense has requested all city civil defense authorities to ask the local county medical society for aid in planning medical aspects of their civil defense program. When medical teams are needed, the county society is to be asked to name the physicians who will take part.

(2) In counties in which state mobile medical civil defense teams are located, the team captains shall be appointed by the county society and the society shall be responsible for the proper organization, training, and maintenance of those teams.

In so far as emergency medical care is concerned, the state civil defense program calls for the establishment of 100 mobile medical teams. These teams are to be located in the following counties:

County	*No. of Teams*
Brown	8
Chippewa	2
Columbia	1
Dane	12
Dodge	1
Douglas	2
Eau Claire	3
Fond du Lac	5
Green	1
Jefferson	2
Kenosha	6
La Crosse	4
Manitowoc	4
Marathon	3
Marinette	2
Monroe	1
Oconto	1
Outagamie	4
Ozaukee	1
Portage	1
Racine	8
Rock	6
Sauk	1
Shawano	1
Sheboygan	4
Walworth	1
Waukesha	4
Winnebago	6
Wood	2

The state has been divided into eight civil defense districts, each of which has a medical director for civil defense who is a physician. The 100 mobile medical teams in Wisconsin are in various stages of organization, and many of them are well-established. These mobile teams should be the major concern of county medical societies engaged in civil defense activities.

The committee wishes to point out that the primary problem in event of disaster is one of individual survival. The committee is somewhat disturbed at the lack of awareness on the part of the civilian population of the importance of developing an adequate civil defense plan. It feels that the problem goes beyond the physician and that, while every effort has been made to apprise the medical profession of the problem and while these efforts have largely been successful to the extent that nearly 100 mobile medical teams are now in various stages of operation, the fact remains that the population does not yet appear willing to fulfill its responsibility for providing personnel for the medical teams. It will be noted that 23 out of the 29 members of each team are nonprofessional people. It has proved most difficult indeed to find 23 nonprofessional people for each of the 100 teams who are willing to devote time to first aid and civil defense training and maintain a reasonable degree of interest in the team over an extended period.

The committee has held many meetings during the past year with state and regional civil defense leaders in an effort to establish workable patterns of operation and develop coordination with other activities related to the civil defense problem such as transportation, communication, fire, and the like. The committee is sending monthly bulletins to all mobile medical team captains and deputy captains. Articles appear each month in the *Wisconsin Medical Journal.* A great deal of correspondence has been carried on by the committee with various county medical societies in which mobile medical teams are located. The committee is always available and has often been consulted by county societies seeking information on how to proceed with their own local civil defense problems.

A manual on mobile medical team operation has been distributed to all teams and is available to every member of those teams for study and training purposes. The committee wishes to commend the outstanding work of Warren Southworth, Ph.D., director of the Health Education Department of the University of Wisconsin, who was given a six months' leave of absence to prepare and compile the manual and to study the civil defense organization in the state and make recommendations for its improvement. His studies, which have had the full cooperation of the Committee on Civil Defense, have proved invaluable in bringing the civil defense planning in Wisconsin to its present stage of readiness.

Physicians who are cooperating with the state civil defense organization and this committee have rightly insisted that certain basic minimum supplies be available, not only for training purposes, but to make it possible for the team personnel to work effectively in the event of a disaster. The Committee on Civil Defense is impressed that the major civil defense accomplishment of the past year has been the foresight and cooperation of state civil defense officials in stock-piling these supplies. Equipment and supplies do exist in stock piles in Wisconsin at the present time. With these supplies actually available to the physicians, there is no reason why the medical profession cannot devote its full attention to plans for placing the mobile medical teams in the field if needed.

Since the medical teams are intended to provide only lifesaving or first-aid care and to stabilize patients for movement to definitive treatment facilities, the team supplies include about 500 lbs. of such items as morphine, antibiotics, litter cots, blankets,

dried plasma, dressings, splints, basins, and lanterns. About $300,000 in medical supplies have been ordered for the Wisconsin stock pile, and about two-thirds of these have been delivered and are now stored at Camp Williams ready for instant transport to the teams going to the scene of a disaster. When delivery is completed, the material will be packaged into 100 duplicate units.

A federal depot from which Wisconsin can be allocated material is located in Northern Indiana at an estimated distance of six to ten delivery hours. More than $3,000,000 worth of medical supplies are currently in stock at this depot; and, when completed, the stock pile will have substantial amounts of nearly 100 different medical and hospital care items.

Recommendations

(1) The committee feels that it is impractical to maintain 100 teams of 29 members each in a full-strength, stand-by state of readiness. Instead, each county medical society responsible for mobile medical teams should be apprised of its responsibility for delivering a fully-manned team into the field upon short notice; and so long as each county society can assure the state director of civil defense that these teams can be delivered when needed, an adequate state of readiness prevails.

(2) To accomplish this, each county medical society should be held responsible for the maintenance of a mobile medical team cadre, each cadre consisting of the captain and his deputy (both physicians), a business manager, dentist, and a nurse. Periodically, the county should be called upon by the State Office of Civil Defense to report the personnel compromising these cadres. In addition, there should be annual exercises in each civil defense area, one area at a time, in which *all elements* of the mobile medical civil defense battalion will participate. For this, each medical team will be expected to mobilize a full complement of personnel. The responsibility of this mobilization will rest with the county medical society and the previously designated cadre.

It is the opinion of the committee that the successful maintenance of an adequate civil defense organization over a long period of time depends on these annual exercises.

(3) Within the structure of each county medical society, it should be emphasized and re-emphasized that the medical profession has a responsibility for maintaining a complete awareness of its civil defense responsibilities. Each society must assure itself that it has ready accessibility to a sufficient number of civilian personnel to assemble a fully-manned team at moment's notice.

To this end, the cooperation of local newspapers, radio stations, and television stations must be secured as a means of maintaining the interest of the civilian population in civil defense and the state of readiness of the respective mobile medical teams. The responsibility for the maintenance of mobile medical teams is in many respects just as important a community responsibility as it is a medical responsibility. It should be obvious, because of the make-up of the mobile teams, that the medical profession cannot be expected to accomplish any more than the civilian population is willing to accomplish. We know of no way that this can be more favorably influenced than by the maintenance of an adequate publicity and education program. It is recommended that at least once each year the county medical society sponsor a public meeting of civil defense to which every member of the mobile medical teams be invited as well as other interested persons and that all physician members of mobile medical teams and county civil defense committees attend this session. It is further recommended that the state headquarters of civil defense be responsible for providing pertinent educational and training material, including the latest films, exhibits, and literature on civil defense, to the county medical societies for these meetings.

(4) The present activities of the Committee on Civil Defense of the State Medical Society and the State Office of Civil Defense in producing and disseminating information about the planning, organization, and training of mobile medical teams should be continued in the *Wisconsin Medical Journal*, bulletins, and releases through other available media.

(5) A copy of this report should be sent to the state director of civil defense and such other civil defense officials as he may designate.

(6) A copy of this report should be sent to the officers of the State Medical Society, the president and secretary of each county medical society, the area co-directors, and the mobile team captains and deputy captains of the state civil defense organization for medical teams.

COMMITTEE ON MILITARY MEDICAL SERVICE

F. L. Weston, Madison, chairman; M. J. Musser, Madison; J. M. Sullivan, Milwaukee; M. H. Steen, Oshkosh; O. G. Moland, Augusta

Members of the Society's Committee on Military Medical Service counsel the Wisconsin Advisory Committee to Selective Service and the Armed Forces on problems relating to the availability of physicians for military duty. Your Society committee chairman also serves as chairman of the Advisory Committee. In addition, the Advisory Committee is composed of the state health officer and representatives of the dental, veterinary, and nursing professions. All activities of the Advisory Committee are financed by the federal government except for staff assistance and file space, which has been provided from within the State Medical Society.

To properly implement the work of the Advisory Committee it seemed to the Council wise, as well as public spirited, that the profession meet its responsibility most effectively through utilization of staff machinery and facilities. Accordingly, detailed and often voluminous studies are undertaken in various areas of the state to assure that recommendations of the committee are made in light of all facts and are realistic in every sense of the word. Staff assistance amounts to full time of one individual, although work is shared to some extent. The committee has all the membership files of the Society at its disposal.

The Advisory Comittee has had under its consideration nearly 2,000 individuals, of which 50 per cent have been physicians. Reports on their availability or essentiality have been made to Selective Service and the Armed Forces. Currently, there are

135 members of the State Medical Society in active military service. Through information obtained from the councilors and other members of the Society, as well as from communications or conferences with officials of the communities concerned, the committee has conscientiously attempted to provide fair and equitable evaluations of the availability of all who come under its consideration.

In light of the changing needs of the nation for military manpower, the problems before the committee at any one moment may change almost overnight. This was demonstrated most vividly within the past month, when, in the midst of plans for the processing and eventual induction of a large number of physicians in the middle age bracket, the Department of Defense issued orders resulting in the cancellation of all inductions through Selective Service.

Thus, at the present moment, the military service situation can be summarized as follows:

> The Armed Forces do not expect to levy a call for physicians at least until July 1, 1954. Local Selective Service boards will, however, continue to classify individual physicians.

The committee desires to caution the Council, the House of Delegates, and the membership at large that the current moratorium may be only a temporary one. The committee must continue to maintain up-to-date records on the availability or essentiality of physicians so that Selective Service may establish a "pool" of available practitioners from which to draw in event calls are resumed. Physicians who hold reserve commissions and are currently eligible for call under existing priority regulations may expect to be called at the discretion of the Armed Forces. The committee will continue to exercise the utmost caution and reserve in its procedures to the end that the individual physician with a liability for military service has reasonably adequate advance notice of his call to duty.

The committee wishes to express its appreciation to the councilors for their wise and deliberate guidance in helping to carry out the profession's responsibility for civil and military medical needs. Likewise, the advice and counsel of officials of Wisconsin Selective Service have been invaluable. In both instances there has been real evidence of the utmost in cooperation and understanding.

STUDENT AMERICAN MEDICAL ASSOCIATION

Representatives of the Student American Medical Association in Wisconsin had suggested that the House of Delegates of the State Society give consideration to a policy followed by the A.M.A. House, which, by formal resolution, invites representatives of the Student A.M.A. to meetings of the House and its various reference committees as official representatives of the Student A.M.A., but without voting privileges.

The Council referred this proposal to the House of Delegates for its consideration.

(President Griffith later introduced Mr. David LaFond, delegate to the A.M.A. from the Marquette University Chapter of the Student A.M.A.)

SPECIAL REPORT ON THE BRICKER RESOLUTION

In no period of American history has our concept of government of the United States been under such jeopardy.

When the framers of our Constitution thought in terms of international treaties and covenants, they were concerned primarily with problems of international trade, boundaries, and military relations. Beginning several decades ago, international treaties and executive agreements were expanded to include matters of local concern, and were held by the United States Supreme Court to supersede police powers reserved to the states and to create within our governmental structure powers and authorities denied under the laws of the United States.

There follows a resolution adopted by the House of Delegates of the American Medical Association at the Denver 1952 session, and reaffirmed at the New York annual meeting in June 1953, in support of the Bricker resolution, which proposes a constitutional amendment placing some limits on the treaty power.

The Council of the State Medical Society believes that the House of Delegates should record itself in similar fashion, and should declare it to be the individual responsibility of each delegate to carry this message to his county medical society for official action, and to arouse all the interest and support of which he is capable on the merits of the issue so that all individuals and organizations interested in preserving the American form of government may similarly support this important resolution.

RESOLUTIONS ON INTERNATIONAL TREATIES AND COVENANTS

WHEREAS, At a regional meeting sponsored by the Committee on Legislation of the American Medical Association, representatives from the state medical associations or societies of North Dakota, South Dakota, Nebraska, Kansas, Missouri, and Iowa, meeting in Omaha, on November 9, 1952, have been informed that there has been approved a treaty, or treaties, that are in opposition to accepted custom and usual practice of presenting and preparing such treaties; and

WHEREAS, Treaties and covenants are being presented to the Congress of the United States for ratification that have been prepared in such manner; and

WHEREAS, The results of the ratification of such treaties will establish regulations and rules of international relations that are contrary to the adopted laws of the sovereign 48 states of the United States; and

WHEREAS, The ratification of such treaties and covenants provides for regulation of the laws that are contrary to the adopted laws of the United States and of the several states and are in direct

opposition to accepted custom and practice as established in the several states; and

WHEREAS, Treaties and covenants are in the first instance adopted at the International Labor Organization by the vote of representatives who are appointive officials and not elective officials of the United States; and

WHEREAS, The treaties and covenants adopted by the International Labor Organization are then submitted to the United States Senate alone with no opportunity for anyone to appear at committee hearings and with no vote by the House of Representatives of the United States Congress on covenants affecting the lives of United States citizens, which is all contrary to our normal and established process of legislation; and

WHEREAS, Such treaties and covenants may concern such matters as the effect on the high standards of medical care available to the citizens of the United States, on local school laws, on municipal ordinances, on the ownership of private homes, on the ownership and size of farms, on ownership of business, on ownership and control of press, radio, and television, all of which are socialistic in character and encourage the adoption of collective farming and encourage socialistic programs; and

WHEREAS, It was the sense of those who attended this regional conference that positive action should be taken at this time; and

WHEREAS, A similar opinion was expressed by those who attended the North Central Medical Conference in Minneapolis, on Nov. 15, 1952; now therefore be it

RESOLVED, That the House of Delegates of the American Medical Association be respectfully requested to adopt, at the 1952 Clinical Session, an appropriate resolution expressing the disapproval of the intent and purpose of such treaties or covenants containing such provisions and that the Congress of the United States be memorialized to disapprove and not ratify such treaties and covenants; and be it further

RESOLVED, That the House of Delegates of the American Medical Association, by resolution, instruct its secretary to forward copies of the resolution to all constituent state and territorial medical associations or societies; and be it further

RESOLVED, That the House of Delegates of the American Medical Association, by resolution, instruct its secretary to send copies of the resolution to all members of the Congress of the United States of America and such other officials of the federal government as it may deem advisable; and be it further

RESOLVED, That the House of Delegates of the American Medical Association, by resolution, reiterate and reaffirm its endorsement of the proposed amendment to the Constitution of the United States relating to ratification of treaties and covenants which has been proposed by Hon. John W. Bricker, United States Senator from Ohio.

REPORT OF THE PRESIDENT

President J. C. Griffith: Mr. Speaker, fellow officers, members of the House of Delegates and guests: The work of this House is ahead of it, not behind it. There is a great deal to do. The accomplishments of the past year are not as important now as the work ahead. What I say to you now is not as important as what you will hear from your incoming president, Dr. H. Kent Tenney of Madison.

I do believe, however, that as a starting point for this meeting some observation as to the present state of affairs in our Society, and a report to you of any progress that may have been made during the past year, may have some value in preparing us all for the work ahead.

Just a year ago this body authorized the new Commission on State Departments. Because of the existing activity of the state government and many private agencies in the health field, it was deemed necessary to have a well-organized structure of the Society to present the profession's viewpoint in matters concerning the health of the people of Wisconsin. This has been a large undertaking, but it stands today as an accomplished fact.

You will receive the report, and you will observe in your Handbook the work already done and the programs and activities planned for the future, with the various subcommittees already at work on what has been planned for them.

The Commission, as you know, is made up of Divisions on Tuberculosis and Chest Diseases; Maternal and Child Welfare; Hearing and Visual Defects; Rehabilitation; Geriatrics; School Health; Public Assistance; Crippled Children; and Mental Hygiene. You will note that the various committees are made up of men well versed in the various fields.

You will note that the Division on Crippled Children, cooperating with the State Bureau of Handicapped Children, has made a study of orthopedic clinics in the state, a study of rheumatic fever, and of cerebral palsy.

The Division on Geriatrics, cooperating with the State Board of Health and the Board of Public Welfare, has been studying the medical care, housing, nutritional needs, and problems of an ever-increasing old age group.

The Division of Maternal and Child Welfare is actively engaged in its study of maternal mortality. The maternal death rate is low in Wisconsin, but it can always be lowered still further.

This is an intensive study of all facts connected with every maternal death in our state. The facts are studied carefully, and the names of the family physician, the hospital, and the community are held in strict confidence. If there are any recommendations for improvement, they are sent to the individual, to the hospital, or to the hospital chief of staff. This Division is also considering care of the premature, and fetal neonatal deaths.

The Division on Nervous and Mental Disease has been actively working for intensified examinations in county institutions, as well as the isolation of those with tuberculosis in these institutions. It has been active in the state legislature with laws per-

taining to the epileptic. Its Subcommittee on Commitment Laws has been working with a committee of the County Judges' Association. Its Subcommittee on the Emotionally Disturbed Child has been studying existing facilities and inadequacies in the care of these children.

And so on down through the other Divisions of the Commission. Those on Public Assistance, Rehabilitation, School Health, Tuberculosis and Chest Diseases, Visual and Hearing Defects, have been organized and are becoming acquainted with the problems as they exist, and initiating intelligent programs to cooperate with the many state and private agencies.

Another high light of the activities of your Society has taken place during the past year under the direction of the Commission on Prepaid Plans. It has seen the completion of the changeover from the previous benefit schedule of Wisconsin Physicians Service to the new A and B programs, with their revised benefits and full-payment provisions.

Even with this changeover, Blue Shield has increased its coverage by nearly 20,000 persons, to a total of nearly 280,000 people. It has seen the launching of plans for catastrophic insurance and community enrollment. The latter program was instituted in Manitowoc County in mid-August, its primary purpose being to offer Blue Shield surgical-medical protection and Blue Cross hospital coverage to persons who heretofore have been unable to purchase them because of their employment at places where there are not enough employees to form a group, and secondly to contact eligible groups wh'ch do not have Blue Shield–Blue Cross protection and offer them an opportunity to enroll. This trial run has provided valuable experience for similar campaigns in the future.

The past year also has seen the establishment of basic policies for the distribution of gamma globulin, used in the control and treatment of poliomyelitis. It has seen the further development of the Grievance Committee in its responsibility for providing a facility to which the public may bring its problems and complaints, and through which the practice of medicine in its economic, social, and scientific aspects may be continually improved.

The Council on Medical Service, in June of this year, appointed a special Committee on Nursing Education and assigned to it the study of the shortage of nursing personnel especially as it is affected by present facilities and standards of nursing education. The committee has held two meetings devoted chiefly to orientation toward the problem and basic fact-finding. Subsequent meetings will be devoted to ways and means by which the supply of nurses can be increased and by which nurses presently available can be utilized more efficiently and facilities for training more practical nurses can be extended and improved.

This has been a legislative year, also. Fifteen hundred bills went into the hopper, and one out of 10 had some public health implication. It is refreshing to note that the legislators have adopted a revised Medical Practice Act that is in keeping with our times, together with considerable legislation affecting other phases of health.

In each instance the final result has demonstrated that Wisconsin's lawmaking body has recognized that our stand is in the best interests of the public and not prompted by selfish aims. We are indebted to many outstanding legislators, many individuals, to physicians who appeared voluntarily at hearings, and to the hard-working Committee on Public Policy and to a hard-working staff for the result.

Your Society has not been neglectful about promoting the advancement of medical science, augmenting our own knowledge, and keeping pace with medical progress.

Your Council on Scientific Work has conducted postgraduate teaching programs during the year to serve the physician who cannot get away from his practice for more than a few hours at a time. Seventeen of these clinics were held between January 13 and June 25 of this year. A very excellent scientific program is in store for you during these next four days.

I have been invited to attend many county and district meetings during the year and have attended most of them, just as many as I could and still keep up with the work of the committees, the Council, and maintain a practice. As to those I could not attend, I want you to know that I was with you in spirit.

This meeting brings to a climax my year as president of your Society. I believe it has been the best year of my life. The office of president carries with it a dignity and respect that one cannot help but feel as he meets with gatherings of lay and professional people everywhere. He cannot help but sense also that this is not as much a personal attitude as it is one of dignity and respect, which our profession seems to have attained by its work and its attitude down through the years.

Any success that the State Medical Society has attained this year is due to your efforts individually, to those of your many committees, and to those of a very capable staff. I know that much greater success and progress can be expected next year under the leadership of the capable and gracious Dr. H. Kent Tenney.

It has been a privilege to be your president.

REPORT OF THE PRESIDENT-ELECT

The report of the president-elect, Dr. H. Kent Tenney of Madison, was published in the November issue of the *Wisconsin Medical Journal.*

His committee appointments were published in the October Medical Forum section of the *Journal.* With the exception of three new appointments to the Committee on Grievances, these appointments were announced at the time of his address to the House of Delegates. On motion of Dr. A. A. Quisling, Madison, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, they were approved. The three appointments to the Committee on Grievances were announced at the third session of the House of Delegates.

REPORT OF DR. F. L. WESTON, TREASURER

For the Year Ended December 31, 1952

This report, covering the year 1952, specifically related to operations of the State Medical Society which are the direct responsibility of the treasurer. It did not, therefore, include the operation of Wisconsin Physicians Service and the Wisconsin Veterans Medical Service Agency, which are separately reported.

COMPARATIVE FINANCIAL STATEMENTS

December 31, 1952 and 1951

	December 31, 1952		December 31, 1951	
ASSETS				
Cash on Hand and In Banks		$ 11,035.42		$ 24,570.42
Due from Agencies of State Medical Society	$ 3,577.22		$ 66.59	
Due from Student Loan Fund	83.32			
Accounts Receivable—Physicians, Employees and Other	644.94	4,305.48		66.59
United States Government Bonds		24,053.99		14,240.63
Working Capital Advances				
Wisconsin Physicians Service	$ 29,000.00		$ 29,000.00	
Wisconsin Veterans Medical Service Agency	7,500.00		7,500.00	
Wisconsin Medical Journal	1,240.18	37,740.18		36,500.00
Building and Equipment				
Land	$ 32,500.22		$ 16,616.10	
Building	31,969.00		31,969.00	
Building Improvements	16,972.73		16,229.12	
Furniture and Equipment	16,847.63		9,625.82	
Total	$ 98,289.58		$ 74,440.04	
Less: Depreciation	12,543.84	85,745.74	8,804.10	65,635.94
Accrued Interest Rec.		292.54		
Prepaid Expenses and Deferred Charges		1,722.26		
TOTAL ASSETS		$164,895.61		$141,013.58
LIABILITIES				
Due Agencies of State Medical Society	$ 219.92		$	
Vouchers Payable	6,361.96			
Due American Medical Association	79.75			
Prepaid Income				
Exhibit Space Rentals	4,387.00		5,202.75	
Postgraduate Clinics	1,442.00			
Membership Dues	1,235.00		332.50	
Dues Suspense	323.20			
TOTAL LIABILITIES		14,048.83		5,535.25
NET WORTH				
Surplus, General Fund	$149,581.60		$135,478.33	
Donation	25.00			
Net Worth of Wis. Medical Journal	1,240.18			
TOTAL NET WORTH		$150,846.78		$135,478.33

RECONCILIATION OF NET WORTH

December 31, 1952

Net Worth—December 31, 1951		$135,478.33
Additions:		
Excess of 1952 Income Over Expenses	$17,811.65	
Donation—Dr. Olin West	25.00	
Net Worth of Working Fund	860.42	
Net Worth of the Wisconsin Medical Journal and Reserve for Blue Book, December 31, 1952	1,240.18	
Total Additions		19,937.25
		$155,415.58
Deductions:		
1951 Expenses Paid in 1952	$ 3,308.80	
1952 Prepaid Membership Dues Reflected in 1951	1,260.00	
Total Deductions		4,568.80
Net Worth—December 31, 1952		$150,846.78

INCOME AND EXPENSE

January 1, 1952 to December 31, 1952

INCOME		
Rental Income		
Wisconsin Physicians Service	$ 6,804.00	
State Medical Society	7,800.00	
Wisconsin Veterans Medical Service Agency	2,532.00	
The Wisconsin Medical Journal	384.00	$ 17,520.00
Cafeteria Income		7,692.10
Membership Dues		165,259.18
Health Conferences		1,013.35
Medical Service Panels		151.00
Annual Meeting—Exhibit Space	$12,827.50	
Annual Meeting—Round Tables	3,512.75	
Annual Meeting—Other	9.00	16,349.25
Teaching Clinics—Industrial Health	$ 2,600.00	
Teaching Clinics—Postgraduate	3,858.00	6,458.00
Prepaid Plans		5,890.70
Interest Earned	$ 409.85	
Less: Amortization of Bond Premiums	19.23	390.62
Miscellaneous		937.29
TOTAL INCOME		$221,661.49
EXPENSE		
Building		
Custodian	$ 2,500.00	
Switchboard Operators Salaries	2,547.34	
Telephone and Telegraph	1,782.02	
Insurance	286.49	
Heat	901.70	
Gas, Light and Water	748.61	
Repairs	489.72	
Supplies	358.29	
Property Taxes	1,421.44	
Social Security Tax	75.82	
Wisconsin Unemployment Tax	50.48	
Federal Unemployment Tax	15.14	
Group Insurance	101.50	
Mail Service	540.01	
Depreciation	3,434.57	
Miscellaneous Expense	363.70	
Total	$15,616.83	
Cafeteria		
Salaries and Wages	$ 2,870.94	
Food Purchases	5,039.77	
Beverage Purchases	1,223.01	
Supplies and Miscellaneous	120.98	
Social Security Tax	43.04	
Wisconsin Unemployment Tax	28.71	
Federal Unemployment Tax	8.61	
Group Insurance	65.60	
Depreciation of Dishes, Linens and Silverware	6.76	
Total	9,407.42	
Totals Carried Forward	$25,024.25	$221,661.49

Totals Brought Forward		$ 25,024.25	$221,661.49
Central Office—Normal Operating Expense			
President's Travel and Reimbursement	$ 750.00		
Council, Officers, Delegates and Committee Meetings	11,047.86		
Association and Dues Expense	744.60		
Resource and Informational Material	886.00		
Woman's Auxiliary	974.14		
Accounting	260.67		
Insurance	495.56		
Rent	7,800.00		
Telephone and Telegraph	2,396.37		
Office Supplies	4,979.32		
Postage and Printing	4,910.25		
Upkeep and Fixtures	489.68		
Depreciation	298.41		
Legal	4,100.00		
General Bulletins to Members	811.73		
Blue Book Issue	900.00		
Miscellaneous	910.08		
Total		42,754.67	
Public Health Information—Special			
Today's Health	$ 408.00		
Lay Publication	81.00		
Special Bulletins	95.00		
Special Telephone and Telegraph	103.68		
Legislative Counsel	3,614.25		
Total		4,301.93	
Public Health Information—Press and Radio			
Press Releases	$ 566.56		
Health Conferences—Exhibits and Publications	3,978.54		
March of Medicine—Recording	944.60		
March of Medicine—Supplies	174.04		
March of Medicine—Printing and Postage	704.11		
Miscellaneous	87.96		
Total		6,455.81	
Medical Service—Open Panels			
Applications and Correspondence	$ 89.75		
Printing	5,175.80		
Total		5,265.55	
Annual Meeting			
Auditorium Rental and Labor	$ 1,606.00		
Speakers—Travel	958.61		
Publicity and Programs	737.48		
Program Chairman	100.00		
Union Operators	195.00		
Scientific Exhibits	1,504.83		
Stenotype Record	187.37		
Commercial Exhibits	1,547.90		
Insurance	10.00		
Round Tables—Dinner—President's Reception and Guest Luncheon Expense	5,134.40		
Badges	82.41		
Staff Costs— Railroad—Rooms	1,557.39		
Smoker	873.47		
Auxiliary	414.40		
Signs, Awards, Postage and Miscellaneous	408.42		
Postage	300.00		
Machine Rentals	192.80		
House of Delegates	1,144.00		
Total		16,954.48	
District Meetings			
Teaching Clinins—General	$ 5,562.96		
Industrial Health Clinics	2,765.27		
Councilor District Meeting	499.49		
Total		8,827.72	
Wisconsin Medical Journal		4,200.00	
Totals Carried Forward		$113,784.41	$221,661.49

Totals Brought Forward		$113,784.41	$221,661.49
Veterans Agency and Prepaid Plans			
Wisconsin Plan—Printing Panels	$ 1,169.92		
—Postage	7.60		
—Legal	1,189.51		
—Telephone and Telegraph	26.79		
—Miscellaneous	13.75		
Total	$ 2,407.57		
Experimental Programs	257.66		
Veterans Medical Service Agency	942.85		
Actuarial Expense	142.70		
Total		3,750.78	
Interim and Special Appropriations			
Student Loan Fund	$ 3,000.00		
State Historical Society—Survey	1,800.00		
Total		4,800.00	
Travel			
Secretary	$ 2,414.26		
Assistant Secretary	1,028.33		
Director of Public Information	1,073.20		
Field Secretary	807.49		
Claims Manager	167.20		
Medical Advisor	31.08		
Total		5,521.56	
Group Insurance		840.05	
Social Security Tax		683.39	
Wisconsin Unemployment Tax		413.61	
Federal Unemployment Tax		124.09	
Payroll—Executive Staff		39,593.36	
Payroll—Other		34,338.59	
TOTAL EXPENSE			$203,849.84
Excess of Income over Expense			$ 17,811.65

CONDENSED STATEMENT OF INCOME AND EXPENSE

January 1, 1952 to December 31, 1952

INCOME		
Rental Income		$ 17,520.00
Cafeteria Income		7,692.10
Membership Dues		165,259.18
Health Conferences		1,013.35
Medical Service Panels		151.00
Annual Meeting		16,349.25
Teaching Clinics		6,458.00
Prepaid Plans		5,890.70
Interest Earned Less Amortization		390.62
Miscellaneous		937.29
Total Income		$221,661.49
EXPENSE		
Building	$15,616.83	
Cafeteria	9,407.42	
Central Office—Normal Operating	42,754.67	
Public Health Information—Special	4,301.93	
Public Health Information—Press and Radio	6,455.81	
Medical Service—Open Panels	5,265.55	
Annual Meeting	16,954.48	
District Meetings	8,827.72	
Wisconsin Medical Journal	4,200.00	
Veterans Agency and Prepaid Plans	3,750.78	
Interim and Special Appropriations	4,800.00	
Travel	5,521.56	
Group Insurance	840.05	
Social Security Tax	683.39	
Wisconsin Unemployment Tax	413.61	
Federal Unemployment Tax	124.09	
Payroll—Executive Staff	39,593.36	
Payroll—Other	34,338.59	
Total Expense		203,849.84
Excess of Income Over Expense		$ 17,811.65

STATE SELECTIVE SERVICE REPRESENTATIVES INTRODUCED

Dr. F. L. Weston, chairman of the Wisconsin Advisory Committee to Selective Service, introduced Major C. L. Shepard, administrative assistant to the director of Selective Service; and Lieutenant Colonel Bentley Courtenay, state director of Selective Service, who was asked to address the House of Delegates. Excerpts from Colonel Courtenay's address follow:

"The success which you and we have enjoyed is due partially to our efforts, partially to your efforts, but I believe is due materially to the fact that it incorporates most of the ingredients of good government. I should like to explain what I mean.

"First, you had a need which we all recognized; and that is one of the bases of good legislation—that there be a need for it.

"Next, you had a very well-conceived law that was some time in preparation and therefore was not hastily written.

"Next, you turned it over to an organization which was long experienced in the field, well staffed, well trained, and readily able to handle the administrative burden.

"Next, you mandated that organization to turn to recognized experts and specialists and the representatives of the professional groups themselves for counsel.

"Next, we had the good fortune to know each other at the state level, and there was developed quickly a very high degree of cooperation between the Advisory Committee, the Society, and Selective Service.

"Lastly, we had people who very much desire to deliver good government. By that I mean effective, fair, economical administration, performing the prescribed mission with a minimum of fuss and controversy.

"I think that has been done. We are grateful that you appreciate our share and our contribution. We readily concede that we could not have done it without your able help.

"All of those ingredients are going to be present in the following year. What the future will portend, I cannot tell; but, by the same token, the draft call for all registrants was predicted to stay down to 23,000 for the balance of this fiscal year. You and I have already seen Mr. Hanna's prediction that the number will go up to about 35,000, or an increase of some 12,000 in January.

"Therefore, I would ask you to take the prediction regarding the 'no call' of doctors and dentists until next July with a grain of salt, and that you allow your representatives to work with our representatives so that we will be ready for anything and so that we will impose upon the members of your profession no avoidable or unnecessary or undue hardship over and above the hardship which going into service will represent.

"I think the future is bright. Thank you."

REPORT OF THE SECRETARY

The following report of the secretary was published in the Delegates Handbook:

The occasion of the annual report of the secretary possesses a value probably not particularly discernible unless commented upon by the occupant of that office; for in the necessity of its annual preparation, not only is the secretary impelled to review for himself the work of the staff during the past year, but to estimate the requirements of the year and years ahead.

Out of every session of the House of Delegates arise new projects, new activities, and indications of coming patterns and future trends. What may be expressed in one year as a possible problem, often develops as such, sometimes a year or several years later; and at the point of its becoming crystallized, the medical profession takes action upon it through the House of Delegates. A staff which is not alert to these situations is caught unprepared and is unable to implement whatever the action of the House of Delegates may be.

Problems of the Moment

Your secretary reports to you now circumstances which lead him to the belief that medicine is turning its attention to the future more than to the present. For the past several years, the most immediate pressures have been upon problems of the moment. Actual experience with the prepaid plans indicated the need of substantial revision to eliminate inequities and to provide more realistic patterns for the beneficiaries.

General reorganization of a number of standing committees was brought about by the realization that governmental activities in public health have been so dispersed among various agencies that only through concentration within the profession itself could uniformity of patterns and proper evaluation come about.

With recognition on the part of the profession throughout the country of other phases of its public responsibility, there came into existence,—or better stated, into greater activity,—the Grievance Committee and the opportunity available to the public to have its problems considered through this means.

The problem of home-town care for the veteran has been a development of but a few years' standing. The past legislative session saw the successful enactment of the revision of the Medical Practice Act.

These are but a few examples of the rather consequential, but immediate, activities of the past several years. Emphasis upon them led not only the staff, but the membership generally, to be thinking in terms of the moment, and less in terms of planning for the future.

However, the State Medical Society of Wisconsin has never rested upon its oars; and there is no indication that it will ever do so. The indications are all to the contrary.

Planning for the Future

Under the direction of the Committee on Medical Education and Hospitals a most comprehensive International Business Machines procedure is now being developed for the purpose of preparing pe-

riodic statistical reports concerning distribution and other vital information about physicians and their general availability to the people of Wisconsin. These reports, while they will be interesting at the time published, will be invaluable in the future as they illustrate problems that can only be shown by studies conducted over a period of time. It will be the House of Delegates a generation hence which will review these surveys, in determination of various policies of the Society intended to further protect the public health interests of the people of this state.

Under direction of the Grievance Committee there is in preparation a code of interprofessional relations to guide physicians and attorneys in the future. As it looks now, this code will be patterned after the Principles of Medical Ethics and Canons of Professional Ethics of the American lawyer. This has long been in preparation; and much is yet to be done with it; but when completed, distributed, and understood, it is the prophesy of the secretary that circumstances which sometimes cause strained relationships between the professions will be largely eliminated. Each will have a better and more sympathetic understanding of the problems of the other.

Prepaid insurance now has its foundations well laid. But here again comes another example of advanced thinking and planning. The Commission on Prepaid Plans is in direction of a study of so-called catastrophic insurance,—an inadequate description, however, of what the Commission itself is considering. Many of the so-called catastrophic insurance programs are related to dreaded diseases, such as poliomyelitis, encephalitis, and others. The American public apparently wants more than a limited program, and it is clear that what the American public wants, it generally also needs.

When catastrophic insurance will come to Blue Shield of Wisconsin is not within the ability of the secretary to predict at this time; but that it is coming and that it will be realistic and effective appear most evident from current work in the field.

There is growing evidence of recognition on the part of the profession that problems of medical education and education in ancillary fields related to health cannot be divorced from the interest of the medical practitioner. The Council on Medical Service has a special committee designed to cooperate with representatives of nursing organizations in the solution of problems of particular concern to that group. In this connection it is to be noted that the Woman's Auxiliary has done magnificent work in the field of nurse recruitment to the point that it deserves a special note of commendation.

These interests are all pointed at examining the situation today in order to produce a solution for problems that may be anticipated tomorrow.

The Commission on State Departments, while of but recent origin, is obviously getting a grasp of the whole problem; and your secretary anticipates most valuable reports to be presented the House of Delegates in future sessions.

More Emphasis on Planning

It seems to your secretary, then, that we are placing more emphasis upon planning, and that is all to the good. But it does require continued readjustment of staff responsibility and activity; for medicine, like law, "is a jealous mistress."

This report is concluded with statistical information concerning membership, but your secretary cannot let the moment pass,—an all too brief one in a year's work,—without saying to the House, as he hopes he has said in other years, that the staff of the State Medical Society represents a devoted group of employees whose loyalty and interest to the profession often rise far beyond the call of duty. It has been an inspiration to him to work with these individuals; and at the same time, he recognizes that in large part, their loyalty and their interest arise out of the stimulation furnished by those many physicians who have contributed so unselfishly to the responsibilities of the State Medical Society of Wisconsin.

1953 MEMBERSHIP REPORT AS OF JULY 31, 1953

Members paying no dues		230	
(affiliate members	55		
(military service members	103		
(honorary members	8		
(life members	64		
(total	230		
Members paying pro rata dues		32	
(military service members	29		
(new members	3		
(total	32		
Associate members ($10 dues)		38	
Members in residency training ($3 state dues)		96	
Members paying $60 dues		2,729	
Total in compliance with all requirements			3,125
Total delinquent at date of this report			95
Members whose status is pending			53
Total membership			3,273

In supplementary remarks, Mr. Crownhart made the following statements:

We have had a rather interesting year since I was last able to report to you. I am always confronted at this time with the question of how to present to you a philosophy of administration that can be no more static in the office of the State Medical Society than you can be static in the practice of medicine.

We develop, we believe, at your administrative level, policies of administration which are going to be immutable, and we change them almost overnight as your problems and as your projects vary and present the staff with certain other lines of activity.

You have a staff which I think is effective, and which I believe is carrying out, under your direction and the direction of the Council and officers, the policies which you enunciate from time to time.

Probably our most burdensome effort is doing the studying and developing the facts as you wish them presented in order to make your own determinations. I am not going into the matter of Blue Shield, which has presented a tremendous number of problems in the past year; but at the present time, under the direction of one committee, we are accumulating information on licensing laws in other states and actions of other bodies relating to nursing.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

If this House of Delegates approves a report submitted by the Committee on Public Policy, in the next 18 months we will make a comprehensive and factual survey of the chiropractors in this state—where they are, who they are, and what their training has been. Part of that study will include locating and finding out why there are 120 naturopaths, unlicensed, who claim to be in that practice (whatever that practice may be) in the State of Wisconsin.

We are to analyze, under the direction of another committee, all the reporting statutes as they now exist, to see if there are some that are obsolete and others that might be somewhat buried, all to the point of seeing if there is any way to reduce your paper work.

We are asked to put into written form a code of press- and radio-physician relations. A committee of your Society, with staff participation, of course, is working with attorneys to draft an interprofessional code of ethics—something that heretofore, to the best of our knowledge, has not been attempted. There have been some agreements stated between attorneys and the medical profession, but never has anything been carried into those rather vague fields in which sometimes there is too much irritation between two great professions.

At the present time we are asked to cooperate with Dr. T. A. Leonard and his various committees and staff researchers in maternal death studies. If you approve another report, it will be in the field of neonatal and fetal deaths next year.

At the present time we are making comparative studies concerning fee schedules in use by various official state bodies, in an effort to see and to present to the Division of Public Assistance the problem which those may present or do present to you at the present time.

I could go on with a list of probably 50 projects, as we call them in the office. We do our very best, as I have stated repeatedly, not to enunciate policy, but always to explain policy, and we are never afraid to do so under any circumstances.

I conclude these brief remarks by paying my usual but nevertheless very considered appreciation to the boys and girls in the office, who, after all, do the typing and the work, and then I sign my name as secretary.

Since our last report to you there have been recorded in the office of the State Society the deaths of: (Members are indicated by bold type.)

P. R. Currer, Wauwatosa
Donald Waters, Wisconsin Rapids
F. A. Kretlow, Whitefish Bay
Henry Westphal, Glendale, California
Albert C. Hammett, Crivitz
R. J. Goggins, Oconto Falls

The House rose in silent tribute to these deceased physicians.

Introduction of Guests

Speaker Forkin introduced the following guests who were present at this session of the House of Delegates:

Miss Mary L. McCord, executive secretary of the Iowa State Medical Society.
Mr. R. R. Rosell, executive secretary of the Minnesota State Medical Association.
Mrs. C. R. Pearson, president-elect of the Woman's Auxiliary.
Mrs. M. J. Reuter, president of the Woman's Auxiliary.
Dr. E. J. McCormick, president of the American Medical Association.

Excerpts from Address of the President of the Woman's Auxiliary

Mrs. M. J. Reuter, Milwaukee: Twenty-five years ago, in the fall of 1928, the House of Delegates of the State Medical Society of Wisconsin, by resolution, authorized the organization of a Woman's Auxiliary. The result of that decision by that body of men in 1928 is evident today in an Auxiliary consisting of 29 constituent county organizations, totaling a membership of about 1,500, or approximately 50 per cent of the eligible physicians' wives in the State of Wisconsin.

Our basic object, "To cultivate friendly relations and promote mutual understanding among physicians' families," is as important today as at the time this Auxiliary was formed. However, the intent and value of the Auxiliary, after 25 years of existence, have greatly broadened into activities that are more extensive and more productive.

Your favorable consideration of Mrs. Kurten's recommendation a year ago to allow the Auxiliary representation on your committees dealing with matters with which we are directly concerned demonstrated that a sage Society "never underestimates the power of a woman" and capitalizes on the public relations potential of the Woman's Auxiliary.

This year nurse recruitment has had priority on our agenda. Our Auxiliary and the Wisconsin State Nurses Association compiled 500 Nursing Reference Notebooks, which were assembled and delivered by physicians' wives to superintendents and guidance directors in our secondary schools throughout Wisconsin. These Notebooks contained bulletins from every accredited professional and practical nurses' training school in Wisconsin, lists of scholarships available, educational prerequisites, and professional opportunities for future registered and practical nurses.

In addition, to prepare nurses and lay people to interpret the career of nursing to young people in a uniform manner, the Auxiliary and the Wisconsin State Nurses Association sponsored a Speakers' Bureau, which held a series of 12 training "Institutes" throughout Wisconsin. Following these Institutes, 116 high school career program speaking requests were filled.

On the county level, conducted tours of hospitals were sponsored by county auxiliaries for high school students.

Individual county auxiliaries granted 15 student nurse scholarships aggregating $2,600; and in addition, a state student nurse scholarship was established, which is maintained by contribution of the smaller auxiliaries.

Our members are serving on committees formed by the Wisconsin League for Nursing and Recruitment, formed by the Wisconsin State Nurses Association.

THE MEDICAL FORUM

DANE COUNTY HEARS DEBATE ON BRICKER RESOLUTION

ATTORNEYS JAMES E. DOYLE AND ROBERT B. L. MURPHY, right, engaged in an informative debate on the Bricker Resolution before the Dane County Medical Society.

Madison, Dec. 8.—Physicians should be concerned, both as U. S. citizens and as professional men, about the increasing tendency to change domestic law through the use of the treaty-making powers of government, Attorney Robert B. L. Murphy told Dane County Medical Society members in a debate with Attorney James E. Doyle on the subject of the Bricker Resolution.

The society had already approved the stand of the State Medical Society and the AMA, both of which have gone on record as favoring this amendment. The meeting was for informative purposes only, and was attended by about 90 doctors.

Murphy, who is legal counsel for the State Medical Society, said that for the first 130 years in the life of the U. S., treaty making powers were confined to matters connected with other sovereign states such as boundary disputes and the setting up of consulates. Since then, beginning with the "duck" case of 1920, when an agreement in regard to migratory fowl was made by treaty which was in conflict with the express laws of a state, this general pattern has appeared more frequently.

Handful Could Rule

As it now stands, a treaty could be imposed against the will of the various states by an executive agreement ratified, not by two thirds of the Senate, but by two thirds of the senators present at the time the subject was introduced.

The Bricker Resolution, Murphy pointed out, would invalidate any treaty held in conflict with the U. S. constitution. A treaty could become effective as internal law only through legislation which would be valid in the absence of the treaty. It also would require that all executive agreements with any foreign power be regulated by Congress.

Doyle opposed the Bricker Resolution on the ground that it is based on a philosophy of fear. He

(Continued on page 707)

Medical Education Foundation Needs Wisconsin Contributions

Wisconsin physicians are urged to make contributions to the American Medical Education Foundation which seeks to raise ten million dollars each year to meet the annual deficit of the nation's 79 medical schools.

Dr. A. H. Heidner, West Bend, chairman of the fund-raising campaign, emphasizes that this deficit must be met by private funds if the federal government is to be kept out of the picture.

All contributions are tax-exempt, and physicians who will consult the folder that came with Dr. E. J. McCormick's letter to all AMA members may find that a contribution will afford them a saving on their federal income tax return for the year.

It is important that all donations to medical schools be made through the foundation so that the total effort of medicine to help itself may be quoted from the foundation's figures. However, a physician may earmark his contribution for some particular school and be assured that the money will be used for that school alone.

Checks should be made out to the foundation and may be mailed to 535 North Dearborn Street, Chicago 10.

THREE LABOR TO KEEP MEMBERSHIP RECORDS CURRENT

What does the State Medical Society actually do for doctors? This is the fourth in a series of articles explaining the services the society performs for its members.

A physician cannot just walk into State Medical Society headquarters and become a member.

The only portal of entry to the State Medical Society is the county medical society. When a man joins his county society, he also automatically joins the state society and the AMA.

To keep all this straight, and to handle all other matters relating to society membership requires the full time of three staff employees in the State Medical Society's office.

The first step toward membership is licensure to practice medicine and surgery in the state of Wisconsin. Whether a man is being licensed by examination or reciprocity, he has to appear in person before the State Board of Medical Examiners. At that time, he fills out a questionnaire which comes to the state society office and is placed in a personal file which will be kept up as long as he lives.

Sends Welcome Letter

At this time, the state society sends the new licensee a letter of welcome, in which he is told that if he will return a name and address card, his whereabouts in the community where he is locating will be made known to the appropriate county society. On hand, at all meetings of the State Board, is a member of the society's staff who is prepared to furnish information about locations available to doctors in Wisconsin.

When the doctor applies for admission to the county society, he fills out a quadruplicate form with information about himself. The county society retains one, sends one to the state society, and two to the AMA. The AMA keeps one of these and sends the other back to the county society with any additional information it may have in regard to the applicant.

When this process is completed and the county society formally accepts the applicant, the doctor pays his dues and becomes a member.

MEMBERSHIP DEPARTMENT AT WORK

The dues structure of the State Medical Society is very complex in itself, and is carefully indexed in a large kardex file. The amount of dues varies from time to time, and also from place to place, because each county society sets the amount of its own dues. Active membership in the State Medical Society is $60, and in the AMA, $25. Dues are payable the first of the year, but the state society carries members through September before dropping them from membership.

If a physician joins after the first of July, his state dues are prorated on the basis of $5 a month, and his AMA dues for the year are halved.

Informed of Services

As soon as he is actually accepted for membership, he receives from the state society a letter telling of the society's services and facilities, and a quadruplicate form on which he may signify his desire to participate in (1.) the Wisconsin Physicians Service program, (2.) The Wisconsin Plan of voluntary health insurance, (3.) the Veterans' Medical Service Agency and (4.) the Open Panel workmen's compensation program. He also receives the Medical Blue Book, the most recent January issue of the Wisconsin Medical Journal, and a folder regarding the Provident Plan of health and disability insurance for physicians.

The staff people who work on the membership file must keep track of eight different membership classifications in addition to regular active membership.

Resident's dues are only $3. The county society may not charge them more than $2 in addition, and AMA dues are waived.

Dues Scale Complex

Retired physicians pay associate membership dues of $10, and there are also affiliate members who are financially pressed or ill, whose dues are waived altogether.

There are life members, who, having been paid-up members for 50 years, are excused from further dues. Military members have their dues waived during their service with the armed forces. There are also a few honorary members including several from outside the profession, who do not pay dues.

A new classification is educational membership, open to those who are occupied entirely with teaching and research, who receive no money from private practice. Dues of $45 are charged to this group.

The staff people who keep the membership records are also responsible for keeping all addresses up to date and ordering correct address plates for the Wisconsin

British MP Tells About National Health Service; AMA Declines to Arrange Talks

Boston, Nov. 8.—Britain's National Health Service "has come to stay . . . works well and has achieved much in five short years," a spokesman of Sir Winston Churchill's Conservative Government told the first 1953–54 Harvard School of Public Health Forum.

The speaker, Miss Patricia Hornsby–Smith, a member of the British Parliament and Parliamentary Under-Secretary to the Ministry of Health, emphasized that the leaders in her government "do not regard our Health Service as a British export."

"We believe that it works well," she said, "and has achieved much in five short years, and we ask you to judge it on how it meets Britain's needs—not whether the same pattern would or would not be acceptable in America. That is another problem—and is for the American people to decide.

"It is accepted by our country and by all political parties as an essential service. They differ only on matters of emphasis and detail. It is opposed by only a very small minority."

Miss Hornsby–Smith said that it is incorrect to speak of the National Health Service as an insurance program.

"The National Health Service is not covered by the weekly insurance payment (this payment covers cash benefits for unemployment, retirement, industrial injury, maternity and death) but is, in the main, financed by direct grant from the Treasury from monies raised by taxation."

Miss Hornsby–Smith spent six months traveling in the United States under terms of a Smith–Mundt grant.

She abandoned plans for addressing numerous groups on the subject of the National Health Service when the AMA declined an invitation from the British Information Service to arrange bookings of her.

Dr. E. J. MacCormick, Toledo, president of the AMA, explained this refusal in a letter to the Ambassador from Great Britain, which said in part:

"We do not feel it would be at all in good taste for a member of the British Parliament to address public audiences in the United States in support of a socialistic measure overwhelmingly rejected by the American people, when travel in this country is being financed by United States tax funds."

Medical Journal and other mailings of the society. They are currently in the process of transferring information about all members to a set of five IBM cards which will be available for rapid sorting and classification.

They also handle other matters connected with membership such as physician placement, Selective Service, Student Loan Fund applications, and membership in the recently created Section on Medical History. Membership work for the Dane County Medical Society also goes through the hands of this department.

When a physician dies, the membership department is responsible for seeing that letters are sent to the widow which advise her how to wind up her husband's affairs.

States with Most MD's Have Most Applicants For Medical Education

Chicago, Nov. 7.—States with the highest number of doctors per capita have the largest number of young men and women who want to enter medical school, according to statistics compiled by the Association of American Medical Colleges and reported in the **Journal of Medical Education.** It is suggested that the common economic, educational and cultural factors which attract doctors also stimulate students to become doctors.

The District of Columbia had the largest number of applicants for admission to medical schools this fall—19 per 100,000 population, while the doctor ratio is 31 per 10,000 population. New York ranked second with 18 applicants per 100,000 population and a doctor ratio of 20 per 10,000.

The study shows that chances of gaining admission to medical schools are greater for students living in states having state-supported schools. Ten states have no medical schools at all and four have only private schools. All private and some state medical schools accept some out-of-state applicants.

MD's SPEAK AT WATA INSTITUTES

Madison, Dec. 4.—Six Wisconsin physicians and one from Minnesota were featured speakers at the 1953 tuberculosis control institutes sponsored by the Wisconsin Anti-Tuberculosis Association. About 450 persons attended this year.

Those who spoke were Drs. George Shinners, Green Bay; Henry A. Anderson, Stevens Point; Daniel E. Dorchester, Sturgeon Bay; James M. Wilkie, Madison; Louis G. Nezworski, Eau Claire; W. D. Stovall, Madison, S. A. Morton, Milwaukee and Ezra V. Bridge, Cannon Falls, Minn.

Institutes were held at Sturgeon Bay, Merrill, Eau Claire and Beaver Dam.

TIME IS YOUR ONLY REAL ASSET

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

613 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

Disability Specialists since 1892.

A FORUM FEATURE

COUNTY SOCIETY IS BASIS

MEDICAL PUBLIC RELATIONS BEGIN WITH THE PHYSICIAN

By THEODORE WIPRUD

Executive Director and Secretary of the Medical Society of the District of Columbia and Former Business Manager of the Frederic, Wisconsin, Clinic

My definition of good medical public relations is a simple one: A cordial relationship between the medical profession and the public, established by means of constructive action, dissemination of information and persuasion. I propose to apply this interpretation to the county medical society.

Paraphrasing the saying "Charity begins at home," public relations begins in the doctor's office Every patient is a potential spokesman for organized medicine's point of view. The doctor who treats his patients expertly and with understanding of their economic problems is doing a public relations job that can be done by no one else. If, in addition, he is capable of discussing the broader economics issues intelligently, he is that much more effective in creating good will.

What can the county medical society do about the problems which confront organized medicine? Here are some of the things the Medical Society of the District of Columbia has done which I consider essential:

1. A monthly informal get-together of medical society members to discuss the history of the organization, its programs, the various projects it sponsors, what dues are expended for and how current problems of good will and public relations can be solved. This opportunity for discussion of the broad issues facing the medical profession has been tremendously successful and resulted in the improvement and the expansion of the society's public relations efforts, both individually and as an organization.

2. Informal get-togethers for residents and interns. This project brings together a small panel of physicians to answer questions by interns and residents about establishing a practice, maintaining good doctor-patient relations, and understanding current medical problems.

3. Establishment of a grievance committee. About 90% of the complaints received by our committee against physicians had to do with fees; and while the majority of these complaints are not justified

THEODORE WIPRUD

by the facts submitted, physicians are nevertheless at fault for several reasons. First, they have not personally discussed their charges with patients, sometimes refusing to do so; second, they have insisted upon collecting a just bill although the amount is small, not warranting the time devoted to enforcing collection or the good will lost thereby; third, they have allowed the patient to incur a large bill without giving him some idea of the indebtedness he is incurring. Mention is also made of the small minority who charge all the traffic will bear. All of these situations contribute to poor public relations.

4. Establishment of a telephone exchange which we call a medical bureau. This bureau gives information to strangers on how to obtain the services of a physician and also provides emergency service. Not that our system does not have its flaws, but at least we have had few complaints from physicians and many grateful letters from patients.

5. Usually the so-called emergency is not an emergency at all, and physicians, sensing this, are at times reluctant to make calls. Nevertheless, they cannot escape censure by pointing to the unreasonableness of the demands upon them. Good judgment and tact are called for. Even then, there is always the unexpected incident which can do a great deal of harm from the public relations point of view.

6. Periodically, we canvass physicians who subscribe to the medical bureau to ascertain how many of them will accept day or night emergency calls. Those who agree to accept such calls are listed by the districts in which they have their offices and those in which they live. Calls are referred to them according to geographical location. A record is kept of the calls which each physician accepts and refuses. If there are too many refusals with no reasons given, the physician is dropped from the list.

7. We have taken a big step toward the solution of the problem which has plagued the medical profession for years—the provision of adequate medical care at a cost patients can afford. We have a Blue Shield plan with some 350,000 persons enrolled. Our physicians have given generous, if not always enthusiastic support. While these plans are highly successful, they are inadequate in certain aspects of coverage. In the future they will undoubtedly move to provide a limited amount of home and office medical care. Blue Shield plans must also move into the field of catastrophic insurance, particularly for the sickness costs in chronic diseases.

8. Active participation of physicians in civic affairs is necessary if people are to know about the good work that organized medicine is doing. This may involve sacrifices, but it affords unusual opportunities for community leadership and it makes it possible for physicians in such positions to make known the efforts of their medical organizations to provide for the health needs of the community.

9. Friendly and satisfactory relationships with the newspapers is the basis for mutual confidence and workable and generally satisfactory arrangement for the dissemination of news. Recently we invited the editors and managing editors of local newspapers to a dinner. Reporters were not present,

Federal Budgets for Health and Medical Programs in Excess of $1,775,882,197

Washington, Nov. 6.—The federal government will spend slightly more than $1,775,882,197 this fiscal year on the 60-odd health, medical and related programs scattered among 19 different departments and agencies, which it operates. This money will cover to July 1, 1954.

The various medical and health budgets are as follows:

Department of Health, Education and Welfare ----------$340,553,000

This includes the budgets of the Office of Vocational Rehabilitation, the Food and Drug Administration, the Children's Bureau and the Bureau of Public Assistance medical and health payments. It also includes $229,122,500 for the 13 programs which come under the jurisdiction of the United States Public Health Service.

Veterans Administration ----------$747,415,264

Department of Defense ----------$533,311,000

This includes the medical services of the Army, Navy and Air Force, and the office of the Assistant Secretary of Defense who is in charge of health and medical affairs in the department.

Department of State --$14,127,733

This includes the World Health Organization, the Pan American Sanitary Bureau and the International Children's Emergency Fund.

Department of Labor --$ 8,960,000

Foreign Assistance Programs ----------$24,500,000

Department of Interior $27,258,600

This includes the Bureau of Indian Affairs, the Bureau of Mines and the Alaskan mental health program.

Department of Commerce $621,000

This includes the Bureau of Standards and the Civil Aeronautics Administration's flight safety program.

Department of the Treasury ----------$ 2,790,000

This money all goes to the Bureau of Narcotics.

Department of Justice -$1,326,000

This money goes for medical services in 27 federal penal institutions.

Independent Offices ----$68,019,600

This covers the budgets for the National Science Foundation, the Federal Civil Defense Administration, the Atomic Energy Commission (medical), Health Resources Advisory Committee, National Advisory Committee to Selective Service, Panama Canal Zone (medical) and Federal Trade Commission (medical).

Federal Employees Health Programs --$ 6,000,000

Commission on Intergovernmental Relations ----------$ 500,000

Commission on Organization of the Executive Branch of Government ----------$ 500,000

---

and the problems we faced—there are some difficult ones — were frankly discussed. It was a profitable evening for all of us.

The press is not the ogre physicians think it is. Reporters seek facts — pleasant or unpleasant— and are quick to sense evasiveness or hostility. Even if it hurts, doctors should endeavor to cooperate with the press.

Which leads me to my conclusion: Good will is not a cheap commodity; it is, in fact, costly in time and money. In medicine it begins with the key figure—the doctor himself. If he fails to do his part, little will be accomplished. Public relations experts are valuable aides and can do much to further the interests of both patients and physicians. But their efforts will be ineffective unless physicians, who man the front lines of medicine, take advantage of their opportunities to win support for the program of organized medicine.

DANE COUNTY DEBATE . . .

(Continued from page 703)

said it would be needed to protect U. S. policy only if the president, the secretary of state and two thirds of the senate should simultaneously run amok. He admitted that gaps do exist but that there was no reason to close them "by means of a shotgun technique." He said that the Supreme Court would rule invalid any treaty violating constitutional rights of the people.

Murphy pointed out that the Supreme Court has not affirmed its right to set aside treaties since the year 1890, and that it has never in all history set one aside. He used as an illustration the Italian treaty of 1949 which, before it was amended, would have allowed any Italian professional person to set up practice in any state in this country w thout taking any sort of examination, regardless of the state's laws in regard to examination and licensure. He pointed out that one of the World Health Organization covenants now pending would require government control of medicine.

Doyle referred to these examples as "among those horrors that did not happen." He said that the need for executive agreements that can be binding arises out of the need of our diplomats to feel that they can deliver on a promise they make in the process of negotiation.

During the question and answer period which followed the debate, it was pointed out that the American Bar Association has likewise gone on record as favoring the Bricker Resolution. It was also pointed out that in 1918, the Supreme Court had verbally questioned its own right to pass on the validity of treaties.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

Business, Industrial Leaders Discuss Help For Medical Education

Milwaukee, Nov. 12.—About 40 Milwaukee business and industrial leaders met with Colby M. Chester, New York, chairman of the Committee of American Industry, a division of the American Medical Education Foundation, in Milwaukee, to discuss the financial plight of the nation's 79 medical schools.

Chester, honorary chairman of the board of General Foods Corp., is making a tour of major industrial cities along with E. J. Ade, New York, fund-raising director of the project, and Dr. Vernon W. Lippard, dean of Yale Medical School.

Chester told of continuing deficits regularly reported by all medical schools, in spite of their relatively high tuition. He stressed the fact that this money must come from somewhere, and if private sources do not supply it, the Federal government will do so—and the schools will go under government control.

Much of the $10 million sought must come from industry, Chester pointed out, saying that it is "just good business" to insure adequate medical and health care for the future.

If business and industry do not meet the challenge, they will pay out the money anyway, in taxes, and the government will be the boss.

It was pointed out that American corporations have contributed two and a half million dollars in the last three years, but only $20,025 has come from Milwaukee. Yet Marquette University and the University of Wisconsin medical schools have received $62,198 and $58,189 respectively from the foundation.

Valley TB Conference Elects Coon Officer

Minneapolis, Nov. 1.—Dr. H. M. Coon, superintendent of the University Hospitals in Madison, was named vice-president of the Mississippi Valley Conference on Tuberculosis at the annual meeting in Minneapolis in October. Other Wisconsin members elected to the governing council were Dr. Henry A. Anderson, Stevens Point, and Miss Iva Louise Hartman, R. N., Janesville.

PRIVATE AID TO MEDICAL EDUCATION was discussed at a meeting of medical educators and industrialists in Milwaukee recently. Front row, left to right, the very Rev. Edward J. O'Donnell, S. J., president of Marquette University; Dr. Vernon W. Lippard, dean of the Yale Medical School; Colby M. Chester, New York industrialist and chairman of the Committee of American Industry of the National Fund for Medical Education; Robert A. Uihlein, Sr., Milwaukee. Back row, left to right, E. J. Ade, New York, fund raising director of the National Fund for Medical Education; Dr. John S. Hirschboeck, dean of the Marquette Medical School; Dr. O. A. Mortensen, Madison, associate dean of the University of Wisconsin Medical School, and I. L. Baldwin, Madison, vice-president of the University of Wisconsin.—Sentinel photo.

Bauer Made President Of AMA Education Fund

Madison, Dec. 4.—Dr. Louis H. Bauer, Hempstead, N. Y., secretary-general of the World Medical Association and a past president of the American Medical Association, was elected president of the American Medical Education Foundation at the recent AMA meeting.

The organization was founded in 1950 to raise funds among doctors for aid to medical schools of the United States.

Dr. George F. Lull, Chicago, secretary-general manager of the American Medical Association, was elected vice-president. Dr. Edward L. Turner, Chicago, secretary of the A.M.A. Council on Medical Education and Hospitals, was chosen as secretary-treasurer to succeed Dr. Donald G. Anderson, dean of the University of Rochester (N. Y.) School of Medicine, who was elected a member of the board of directors.

"Increasing interest is being shown in medical education, and we are confident that through the efforts of the National Fund for Medical Education and ourselves the problem of financial medical education will be solved," Dr. Bauer said.

"It takes time to build up enthusiasm, but individual contributions are increasing, and so is the total. This year for the first time, contributions from doctors exceeded one million dollars. In addition, another three-quarters of a million dollars was contributed by doctors directly to their medical schools. That is encouraging."

Nearly $5,100,000 has been raised through the efforts of the American Medical Education Foundation and the National Fund for Medical Education. The latter directs its efforts to business, industry and laymen. Contributions from doctors alone, through the A.M.E.F., have totaled nearly $2,700,000.

Langer Will Give a Boost to Chiropractic

Washington, Nov. 9.—Senator William Langer (R., N. D.), chairman of the Senate Judiciary Committee, has announced he intends to hold additional hearings soon in regard to the exclusion of chiropractic from Federal medical services.

According to the Washington Report on the Medical Sciences, he has intimated he may sponsor a bill to compel the Veterans Administration to recognize chiropractic in its medical program.

VA SCREENING PHYSICIANS' REPORTS TO CURTAIL UNNECESSARY TREATMENT

Madison, November 10.—The Veterans Administration has begun more careful screening of "home-town physicians" reports in an effort to curtail what it calls "unnecessary treatment."

Dr. S. E. Sebastian, Chief Medical Officer of the Milwaukee regional office of the Veterans Administration, reports that appropriations to the VA from the Bureau of the Budget have been insufficient "to authorize as generously as we have in the past."

Screening Necessary

He has been instructed by the Chief Medical Director of the VA to "carefully screen fee basis medical authorizations to insure provision of only necessary treatment."

This will be done by screening the reports available from the doctors themselves on file in VA regional office treatment folders.

"We will not continue to authorize treatment in those cases in which we have no information as to progress or in which the physician has reported no significant results of his treatment," said Doctor Sebastion. He called particular attention to the "stereotyped reports we have received from many physicians, reports that never vary over months and months of treatment."

"Since we must curtail unnecessary treatment," Doctor Sebastian emphasized that the "only fair criterion for our authorizing action is need for treatment as demonstrated by the physicians' reports."

Stresses Six Points

Doctor Sebastian said that his department would insist that reports from home-town physicians contain the following information:

1. Physician's own diagnosis of condition being treated.
2. Concise, complete statement of treatment currently prescribed or rendered.
3. Record of all medications and/or prosthetic appliances prescribed.
4. Results of laboratory analyses, EKG's, x-ray findings, and other tests done in connection with treatment. We must have reports on these items before we can pay for them.
5. Professional observations relative to treatment that are sufficient to justify continued treatment if requested.
6. In the case of psychiatric treatment a summary containing—
   a. Psychiatrist's own diagnosis of condition being treated.
   b. Mode of treatment employed (supportive, educative, insight, pharmical therapy, etc.)
   c. Current monthly progress report showing need for continued treatment if requested.

Doctor Sebastian indicated his appreciation for the cooperation of the Wisconsin Veterans Medical Service Agency of the State Medical Society in bringing this matter to the attention of member physicians during past months and urged all physicians to conform immediately with the more detailed reporting requirements.

FIRST AID FOR PROGRAM CHAIRMEN

To attract the attention of Women's Club members to the pamphlets, exhibits and films available through the AMA for building health programs, the AMA recently released a brochure entitled "First Aid for Program Chairmen."

This pamphlet describes the best material available on four subjects of general interest—how to get the best medical care, training medical personnel, overweight and nutrition, and cosmetics.

In the brochure, clubs were advised to contact their state and county medical societies for additional program help, or to obtain physician-speakers for the program.

Any group interested in obtaining "First Aid for Program Chairmen" may write to the State Medical Society, Box 1109, Madison.

Radio, TV Seek Ban on Indiscriminate, Unethical Medical Products Advertising

Madison, Nov. 30.—The television industry and the National Association of Radio and Television Broadcasters have taken steps to curb the evils of poor taste, unethical and indiscriminate advertising as it relates to medical products.

On the subject of advertising of medical products, the NARTB has adopted a television code as follows:

"The advertising of medical products presents consideration of intimate and far-reaching importance to the consumer, and the following principles and procedures should apply in the advertising thereof: (a) A television broadcaster should not accept advertising material which, in his opinion, offensively describes or dramatizes distress or morbid situations involving ailments by spoken word, sound or visual effects. (b) Because of the personal nature of the advertising of medical products, claims that a product will effect a cure and the indiscriminate use of such words as 'safe,' 'without risk,' 'harmless' or terms of similar meaning should not be accepted in the advertising of medical products on television stations."

Dramatized appeals in advertising were also the subject of an NARTB ruling:

"Appeals to help fictitious characters in television programs by purchasing the advertiser's product or service or sending for a premium should not be permitted, and such fictitious characters should not be introduced into the advertising message for such purposes.

"When dramatized avertising material involves statements by doctors, dentists, nurses, or other professional personnel, the material should be presented by members of such a profession reciting actual experience; or it should be made apparent from the presentation itself that the portrayal is dramatized."

The NARTB has been cooperating with the American Medical Association and the AMA has requested all physicians who note programs having sequences believed to be in conflict with the code to report such instances to the Public Relations Department of the AMA.

BYRNES TELLS OUTAGAMIE MD'S TO WATCH VA POLICIES, SOCIALIZATION

Appleton, Nov. 14.—There are still ardent advocates of socialized medicine loose in Washington, Congressman John W. Byrnes, Green Bay, told members of the Outagamie County Medical Society and the Outagamie County Bar Association at a joint meeting recently.

Byrnes told the professional men and women present that it was up to them to make their desires in legislative fields known to their Congressmen. He declared that all too often they fail to take an active enough interest in government affairs.

"Government is your business," he declared. "The views of legislators are dependent largely upon what the people back home think. But too many people who shou'd be the most concerned are too busy with day-to-day operations. They fail to realize that something is being imposed from above that will affect them tomorrow and from then on."

Byrnes also suggested that doctors should be concerned over policies relating to the medical treatment of veterans with non-service connected disabilities. "If we get universal military training, there won't be many men in the nation not eligible for this free care," he stated.

A calm, cautious, economy-minded outlook is evident in Washington today, Byrnes claimed. He said there was some criticism that things are moving too slowly, but that we should "take confidence in that slowness."

"Things aren't being done in an atmosphere of turbulence and haste," he said. "We must stop this 1-year and 2-year legislation and develop a long-range program. We must get away from the day-to-day solutions of the problems of government."

HORSE-AND-BUGGY DOCTOR PATIENTS' CONCEPT OF IDEAL

What makes an "ideal doctor"? Many folks speak nostalgically of the "old family doctor"—the combination physician, father-confessor and friend. Few people would entrust their care to him today, for often he had more sympathy than skill to offer. It is from fond memories of the horse-and-buggy doctor, however, that people draw their conception of the ideal doctor.

To the patient, a good physician is "gentle, kind, even-tempered, always available, tireless, inexhaustibly patient, everlastingly resourceful, and, up to this morning's radio broadcast, completely informed."

A good doctor-patient relationship, often termed "the most important factor in the practice of medicine," depends upon not only giving people the best possible medical service, but in maintaining their confidence and friendship. Too often patients complain that "doctors are cold and impersonal." How do you win the affection and friendship of the patient? Through frank and friendly attention, relief of pain and ease of mind, but above all, by treating patients as people.

Patients want to feel they are important to the doctor as people—not just as clinical cases. Says one physician: "Be glad to see patients, even if your are a little tired; be frank, be prompt, never give the impression you are doing the patient a favor." Skill is no substitute for kindness.

Cold, calculating science can never replace the warmth of a sympathetic personality. Healing the body is not enough. If a physician is to fully meet his medical responsibilities, he must comfort the soul too. This is no task for the psychiatrist alone. It is the plain duty of every practicing MD.

(Note: This is the first in a series of short articles which are being reprinted from the new Public Relations Manual of the AMA.)

Immunization Clinics Resumed in Appleton

Appleton, Dec. 9.—A series of immunization clinics in the Appleton city schools, conducted by the school nurses in cooperation with the Outagamie County Medical Society, was resumed in October.

The second round of clinics started November 9, and the third December 7. These were for the purpose of administering the second and third dosages of triple toxoid.

Representatives in Europe to Observe Socialized Medicine

Washington, Nov. 5.—Republican Representatives Charles A. Wolverton, N. J., Richard W. Hoffman, Ill. and William L. Springer, Ill. left today for Europe to take a first-hand look at the nationalized health services of England and Sweden.

They will also visit Switzerland, France and Italy, inspect the World Health Organization's headquarters in Geneva and spend a week in the Middle East, looking into petroleum supply.

According to the Washington Report on the Medical Sciences, Wolverton carefully refrained from mentioning that he was about to expose himself and his companions to the controversial collection-payment systems which have been adopted by some European countries, when he made a statement before his departure. He spoke of illness costs in this country as being "staggering and catastrophic."

He promised that the hearings on medical care insurance, which were recessed in mid-October, will be resumed in January. "In future hearings, the committee will seek answers—steps that may be taken to alleviate the suffering due to chronic disease and to reduce the tremendous burden to society," Wolverton stated.

No Chance for Snake Oil Spielers Here!

Washington, Nov. 1.—Two of the latest drug preparations to be seized by the Food and Drug Administration for false and misleading advertising were bone meal and bone meal tablets which, according to the labels, could cure the following:

Tense feeling, jagged nerves, restlessness, sleeplessness, tired feeling after shopping, hemorrhages, non-healing wounds, stunted growth, low blood pressure, angina pectoris, facial neuralgia, migraine headache, easy dislocation of the hip, swelling of the ankles, boils, psoriasis, faintness, weakness of the lower limbs, night sweats, hoarseness, dropsy, epilepsy, heart trouble, premature graying of the hair, contracting of the esophagus, blood tumors, and varicose veins.

In response to requests from regional blood banks, our county auxiliaries have been responsible for the volunteer work associated with the visits of mobile blood units.

Our county auxiliaries have participated in many other community welfare projects too numerous to mention. Mrs. Pearson and I attended the Midyear Conference of the National Auxiliary in Chicago and the annual meeting in New York and have visited many of our county auxiliaries during the year. Our Auxiliary ranks thirty-fifth in the national picture.

Some of the state medical societies have taken it upon themselves to recommend to their constituent county societies that Auxiliary dues of physicians' wives be collected simultaneously with their own. The wife of every State Medical Society member is entitled to membership and the privileges of the Auxiliary, and this would insure such an ideal state of affairs. In counties where an Auxiliary has not been organized, the physicians' wives become members-at-large, and, as such, members of the national organization. They also would receive our publication, "The Badger Doctor's Wife," which may help to stimulate their interest in the work of the Auxiliary.

We owe a vote of thanks to the county and state medical societies and to the office in Madison for the courtesy and cooperation granted us during the past 25 years. My sincere hope is that our organization will continue to warrant your interest and help. I know Mrs. Pearson will do all in her power to perpetuate the aims and ambitions of the women who during the past 25 years have given so fully of their time and energy and achieved so much.

Excerpts from Remarks of State Health Officer

Dr. C. N. Neupert: It is a cherished privilege to be invited to appear before you each year. I cherish it on the basis that it is evidence of a genuine interest in the work of the State Board of Health. By working together we supplement each other.

For instance, right now we are pulling together in the poliomyelitis gamma globulin operation. Since I am held responsible and am strictly accountable for the distribution of gamma globulin, together we set up 16 distributing centers. Special allotments of gamma globulin are available for county-wide application if the number of cases exceeds the critical index. Our district health officers weekly compute the incidence of the disease from your reports. They notify the county medical society secretary when the critical index indicates eligibility for gamma globulin for mass prophylaxis. You, as county medical societies, then plan and direct the operation. So far, there has been but one in our state, that in Polk County.

You are all aware of our close cooperation in the maternal mortality study. Your state committee will go on to more studies if you authorize it to do so, and we will try to provide you with the material we can provide.

Twenty years ago, in 1932, there were 1,369 deaths from tuberculosis in Wisconsin. Ten years later the figure was down to 740. Last year it was 223. That is one of the best records in the nation and in the world. But is tuberculosis under control? There were 1,483 cases of actual tuberculosis reported to us last year. The level stays high. Through the use of the antibiotics, plus the use of new resection surgery, deaths have been sharply reduced. But we have about 900 unknown cases in the state, on the basis of comparative studies. These people are spreading tuberculosis to others. A large majority of these people are 45 years of age and over, and many more are men than women.

The State of Wisconsin spent this last year over 5 million dollars in taxes to care for tuberculosis patients. Substantial money is spent in addition. Our combined efforts, those of the practicing physicians and public health people, are necessary in locating the 900-odd unknown cases. I would like to make a special plea that practicing physicians refer their tuberculosis patients to sanitoria for treatment. Seventy-five per cent of them can be most successfully treated with antibiotics and resection surgery.

In August, we were notified that the federal funds to the State Board of Health had been cut 25 per cent from last year. As a result, we have had to do some major retrenching. We have cut out one district office, so that we now have eight. We have dropped or eliminated 26 positions, vacancies, or resignations. Four of them were physicians. Nine other positions are paid from a balance fund in the state treasury, which will be used up in two years. We assume there will be further cuts in federal funds next July.

Roughly, the proportion of funds on which we operate, exclusive of tuberculosis institutions, is as follows: $7 federal, $6 state appropriation, and $3 state fees. You know we have to collect fees from hotels and restaurants, plumbers, and so on.

We will be in serious trouble next July if federal funds are cut further, and they probably will be. Our state legislature will not meet until January 1955, and state funds (if there are any appropriated beyond those now available) will come to us on July 1, 1955, a year after the anticipated cut comes.

We in the Board have always been convinced that we could operate most effectively if all of our funds came from the state. Right now our staff is jittery. It is a fine, devoted, qualified staff. If we must lay them off between now and July 1955, they can't hang on a strap while we try to bring the picture to the people of the state.

Anyone who gives the matter study is confronted with the prospect that if preventive health services are reduced, the effects of health neglect will cost the government considerably more than prevention would have cost.

There is one special credit to which I should like to call attention. That is the fine work of your Civil Defense Committee headed by Doctor Musser. He and the others on his committee are especially qualified through extensive war service. They have given much time to the job of being ready to care for casualties that may well be numbered in the tens of thousands.

These are a few examples of our close, effective teamwork. We are all members of the State Society too. I thank you very much for this opportunity to express my appreciation for your support over the years.

Excerpts from Supplementary Report of Division on Maternal and Child Welfare

Dr. T. A. Leonard: As you will recall, the maternal mortality study was conceived by the Wisconsin Society of Obstetrics and Gynecology in 1951. At that time I presented a request before this House for permission to pursue a maternal mortality study and survey. That permission was granted.

It took about one year to get the plan organized. We wrote to every state in the country in which these studies had been made, and we obtained material from them on the mechanisms of their plans. These plans were gone over by the committee in detail, and eventually we came up with one of our own, which we felt perhaps had certain advantages and certain principles which would make it workable in our particular state.

The conception of this was based on the following principles: In all of the studies that had been made, it was shown that perhaps 50 per cent of the maternal deaths that occurred were preventable.

Our present maternal death rate in this state is about six maternal deaths for every 10,000 births.

At the time of the conception of this plan, there were certain principles outlined as follows:

1. It was agreed by our Joint Committee that, if the plan was to be of value, certain conditions must be met. First of all, it must be thorough.

2. The information obtained on each maternal death must be complete to the finest detail.

3. Such information should be obtained by interviewing the hospital and the physician under whose care the death occurred.

4. The interviewers should be physicians competent to obtain this information.

5. The interviewing physician should be tactful and impersonal, and he should not be a resident of the local or nearby community in which the death occurred.

6. A separate study committee should be created, and the members of this committee should not take part in any of the interviews.

7. All information obtained should be presented to the study committee in a purely anonymous form, with absolutely no information concerning the identity of the patient, the hospital, or the physician.

8. The study committee should include at least one general practitioner among its members.

9. The information obtained should be reviewed in detail, with the application of good, sound obstetric principles and judgment, and the consideration of special circumstances and opinion arrived at as to the preventability or nonpreventability of the death.

10. Each physician under whose care the death occurred should feel free to request a report on the interpretations of the study committee.

11. All information should be under the control of the State Medical Society and will be used purely for study and for purposes relative to the obstetric situation in the state; and, as the information accumulates, it should be summarized and used for educational purposes.

With this in mind, the committee was set up. We have some 30 physicians who act as interviewers. The chairman of that committee designates the physician who is to do the interviewing in a given community.

After the interview is processed, the information comes back to the State Medical Society, and all identifying data are removed. Photostatic copies of it then go to the Study Committee.

So far this year the Study Committee, consisting of six members, has met on three occasions. We have reviewed to date 34 maternal deaths. Obviously, the time which has elapsed from the beginning of this study, from the first of the year until now, has been too short for any conclusive interpretations. However, there are certain trends and patterns which have been established in the deaths that have been reviewed so far.

We have been particularly impressed with the deaths which have occurred from traumatic obstetric procedures. Among the three procedures which have been responsible for maternal deaths have been: (1) Manual dilatation of the cervix; (2) Version and extraction, with improper relaxation because of improper choice of anesthetic agents; and (3) Among these deaths from traumatic deliveries, decomposition of breeches, perhaps too early.

Number two as an important cause of maternal deaths so far has been those deaths which have been due to hemorrhage.

Number three—and this is quite a sizable group—are the deaths which have been due to toxemias. There were occasional fulminating toxemias, but for the most part the toxemic deaths have been those which have had a background of chronic hypertensive cardiovascular renal disease.

Number four. There have been two anesthetic deaths, one from aspiration and the other from caudal which became spinal.

It is hoped that the results of this maternal mortality survey study within a period of about three years will give us a sufficient number of cases to comprise a group for proper statistical analysis. It is hoped further that when this group of cases has been thoroughly analyzed, we perhaps will have information at hand which will be favorable for presentation and favorable for distribution and study and improvement in our current obstetric situation.

We hope that perhaps by presentation at the meetings of councilor districts, presentations at county society meetings, studies of individual cases, and so on, some of these difficulties which are now present in our maternal care situation in this state will be improved.

Excerpts from Supplementary Report of Council on Medical Service

Dr. T. D. Elbe: The Council on Medical Service this year authorized a survey of emergency medical services in Wisconsin. Detailed questionnaires were sent to every county medical society and to each general hospital. The staff personally interviewed many physicians. The information thus obtained was correlated with knowledge of communication facilities, population factors, trade patterns, and police and sheriff's services.

Results of the survey revealed that the services of physicians are available to the people at all hours

of the day or night in every county in Wisconsin, either through the personal physician, some county medical society facility, or the nearest hospital. Some mechanism is available to every county for the rapid handling of emergency cases.

Emergency medical care is particularly accessible to the Wisconsin public by virtue of the fact that a large proportion of the state's 3,000 practicing physicians are located in towns without hospitals.

There are 107 cities in Wisconsin that have one or more general hospitals. Physicians make arrangements through these hospitals for emergency care. Almost without exception, every inhabited part of Wisconsin is less than 25 miles from a hospital. Only two counties are without general hospitals within their borders.

At least one of the following emergency call facilities is available in every community in Wisconsin: a medical society-operated call service, a privately operated physicians' exchange, the nearest hospital with which physicians are certain to be affiliated, or the closest telephone or police office.

In many areas, particularly rural, there are excellent ambulance facilities and good cooperation between police and sheriffs' departments and the physicians and hospitals.

The following recommendations are made to the public:

1. Get to know a physician who will serve your family whenever he is needed. Find out from him BEFORE an emergency arises whom you should call if he is ill, away, or tied up with other patients. Try to be considerate in your demands upon him.
2. Find out before an emergency occurs how to obtain medical assistance from other than your family doctor. Know the telephone number of the emergency call service, if there is one, the nearest hospital, or the police. In small towns remember that the telephone operator may know what to do.
3. In the event of an emergency, don't lose your head. Call the logical sources of medical assistance; and as soon as you are assured that someone will come or you are given instructions to follow, stop calling.
4. Learn first aid so that you can apply emergency measures whenever needed. Also learn the limitations of first aid. Proper treatment requires the skill and judgment of the physician.
5. Maintain a properly equipped first-aid kit in your home, shop, and automobile.

The Council recommended to physicians that:

1. The distribution of first-aid charts prepared by the Society last year be continued, and renewed efforts be made to educate the public and the profession on the proper handling of traumatic injuries.
2. Every county medical society and every medical staff of a hospital periodically review their mechanisms for handling calls for emergency medical service and take steps to remedy any aspects which may result in lapse of adequate service to the public.
3. Medical societies give every possible assistance to the development of more effective emergency call programs through the medical staffs of hospitals, since the hospital is usually the most logical center for treatment of the serious emergency problem.
4. Individual physicians examine their own practices in the handling of night and emergency calls, to assure their own patients of adequate service even when the patients are unable to reach them.
5. County medical societies invite sheriff and police officials to meet with them periodically to establish and maintain reasonable methods of caring for emergency cases handled through law enforcement agencies.
6. The State Medical Society work with the State Highway Patrol to make certain that its patrol units are stocked with the proper first-aid supplies.
7. The State Medical Society urge the State Highway Commission to adopt a suitable symbol for clearly indicating the location of every general hospital in Wisconsin on state highway maps.

Reference of Reports

Speaker Forkin announced referral of reports to the following committees:

To the Reference Committee on Reports of Officers: Reports of the president, the president-elect, the speaker, the secretary, the treasurer, the American Medical Association delegates, and the Woman's Auxiliary; supplementary report of the Council, including the reports of the Committees on Military Service, on Civil Defense, and on the Student American Medical Association.

To the Reference Committee on Reports of Standing Committees: Reports of the Committees on Cancer, Grievances, Hospital Relations, Medical Education and Hospitals, Medical Service and the supplementary report on Emergency Medical Service, Public Policy, Scientific Work, Blood Banks, Commission on State Departments, and the supplementary report on the Maternal Mortality Study.

To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Report on Section Delegate Representation; resolutions on the Section on Medical History, Eliminating Citizenship as a Requirement for Membership, License Revocation and Suspension and Membership Status, Abolishing Time Limit for Speakers, Providing for Educational Memberships; the Report of the Council, including the report of the Commission on Prepaid Plans, Report of the Veterans Medical Service Agency; the special Report on the Bricker Resolution; and dues for 1954.

Speaker Forkin stated that it is a privilege, as well as an opportunity, for any interested member of the Society to appear before these committees and present his views on any matter properly before them.

Announcement was made of the time and place of reference committee meetings.

Committee on Nominations Selected

Following a councilor district caucus of delegates, on motion of Dr. E. J. Schneller, Racine, seconded by Dr. T. J. Aylward, Milwaukee, carried, the following delegates were approved as members of the Nominating Committee:

District	*Nominee*
1	M. J. Werra, Waukesha
2	E. D. Sorenson, Elkhorn
3	T. A. Leonard, Madison
4	O. E. Satter, Prairie du Chien

District	Nominee
5	E. C. Cary, Reedsville
6	H. J. Kief, Fond du Lac
7	Robert Krohn, Black River Falls
8	C. E. Koepp, Marinette
9	R. E. Garrison, Wisconsin Rapids
10	W. C. Henske, Chippewa Falls
11	J. W. Prentice, Ashland
12	J. A. Enright, Milwaukee
13	C. E. Zellmer, Antigo

Adjournment

The first session of the House of Delegates adjourned at 12:25 p.m.

SECOND SESSION

Tuesday, October 6, 1953

The second session of the House of Delegates convened at 2:15 p.m., Dr. G. E. Forkin, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 48 delegates and 11 alternate delegates entitled to vote at this session of the House of Delegates.

On motion of Drs. T. J. Aylward, Milwaukee, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 59 was accepted as the official roll of this session of the House, to stand for the entire session.

Report of Reference Committees

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee was composed of Drs. L. O. Simenstad, Osceola, chairman; S. A. Morton, Milwaukee; W. D. Stovall, Jr., Brodhead; R. H. Bitter, Oshkosh; and L. M. Lundmark, Ladysmith. Doctor Simenstad presented the following report:

REPORT OF THE PRESIDENT

"The reference committee listened to, as well as read, the report of our efficient and genial president. His report to the House was a comprehensive review of the activities of the State Medical Society during the year in which he served as its steward. He proposed no definite recommendations. He did reassure us, and all of Wisconsin medicine, that our leaders, our officers, our councilors, our committee members, and others have endeavored faithfully and efficiently to carry on our recommendations and our purposes.

"We, as members of the House of Delegates, appreciate the services rendered by Doctor Griffith. Mr. Speaker, I move that this House spread upon its records grateful appreciation of his sincerity in leadership, of his congeniality in deliberation, and of his effectiveness during his term of office as the president of the State Medical Society of Wisconsin."

On motion of Doctor Simenstad, seconded by Dr. E. C. Cary, Reedsville, carried, this section of the report was accepted.

REPORT OF THE PRESIDENT-ELECT

"You and others had the privilege of listening to an inspired presentation by the president-elect, Dr. H. Kent Tenney of Madison. He has brought realism to idealism, and it is certain that in the ensuing year he will further the purposes for which we stand.

"We of the reference committee, in reviewing his address, feel that the Medical Society should stand solidly behind the philosophy which he expresses, and which, in fact, is that of the personal physician. Let him who represents a group represent it in its entirety, and in genuine appreciation of its public responsibility.

"I move the wholehearted commendation of this House for the address of the incoming president, Doctor Tenney."

On motion of Doctor Simenstad, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

REPORT OF THE SPEAKER

"The Speaker of the House of Delegates, in his initial statement to the House, suggested the advisability of county program chairmen being approached by each member of the House of Delegates, to arrange time at the first county society meeting following the Annual Meeting for a discussion of actions taken by this session of the House of Delegates. Your reference committee believes this not only advisable but commendable. It is the motion of your reference committee that this suggestion be endorsed by this House."

On motion of Doctor Simenstad, seconded by Dr. W. D. Stovall, Jr., Brodhead, this section of the report was accepted.

REPORT OF THE TREASURER

"Doctor Weston, our treasurer, has submitted an excellent and understandable report. His interest and detailed supervision of Society affairs are evidenced in his report. I move adoption of the report and commendation of Doctor Weston for his untiring efforts for the Society."

On motion of Doctor Simenstad, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

REPORT OF THE AMERICAN MEDICAL ASSOCIATION DELEGATES

"Your delegates to the American Medical Association have developed a tradition existing only in Wisconsin, as far as is known to this reference committee, of publishing as promptly as possible their report and evaluation of transactions of the House of Delegates of the A.M.A. This is a valuable as well as a stimulating service, and reflects the acuity with which the delegates observe and partici-

pate in the transactions of the House of Delegates of the A.M.A. The delegates are to be commended. It is the suggestion of your reference committee that there be special commendation by a rising vote."

On motion of Doctor Simenstad, seconded by Dr. A. T. Smedal, Stoughton, carried, this section of the report was accepted by a rising vote.

REPORT OF THE WOMAN'S AUXILIARY

"Mrs. Reuter carries on the tradition of the Auxiliary, and we are happy that the policy has been recognized of the Auxiliary reporting through its officers to the House of Delegates. In her address was contained a suggestion that in some fashion the dues structure of the Medical Society and the Auxiliary be integrated. It is the belief of your reference committee that, without sufficient opportunity to consider this matter, it should be the responsibility of the delegates to ascertain the wishes of their constituents. Mrs. Reuter, as an individual and in her official capacity, is to be commended for her efforts to further the objectives of American medicine."

On motion of Doctor Simenstad, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this portion of the report was accepted.

REPORT OF THE SECRETARY

"The secretary's report was published in the Delegates Handbook and supplemented by Mr. Crownhart's remarks yesterday. Your reference committee is impressed by the number of projects that are programmed for the ensuing year, but it is always hoped that the number of meetings and long hours of work can somehow be reduced. The secretary and his staff are to be commended for the time and energy devoted to the affairs of the medical profession in this state."

On motion of Doctor Simenstad, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this section of the report was accepted.

REPORT OF THE COMMITTEE ON CIVIL DEFENSE

"The reference committee appreciates that the efforts of this committee are at once frustrating and necessary. Civil defense is viewed with apathy by too many individuals who think only of today and not of tomorrow. The Committee on Civil Defense has a realistic and effective program, and in its development and availability deserves the cooperation of this House and of every county medical society in Wisconsin. Your reference committee recommends adoption of the report, with appreciation of the committee's careful and valuable service."

On motion of Doctor Simenstad, seconded by Dr. D. N. Goldstein, Kenosha, carried, this portion of the report was accepted.

REPORT OF THE COMMITTEE ON MILITARY MEDICAL SERVICE

"Your reference committee was impressed by the oral report of Colonel Bentley Courtenay, as well as a communication in which he commented on the significant contribution of this body in the operation of an unprecedented military procurement program. Your reference committee commends Doctor Weston and the physicians and other professional personnel who have joined in an invaluable service to the citizens of the State of Wisconsin. The reference committee recommends endorsement of the report of the committee, and commendation on behalf of this House of Delegates of the several individuals who have contributed so willingly, so unselfishly, and so effectively in the development of this program."

On motion of Doctor Simenstad, seconded by Dr. A. A. Quisling, Madison, carried, this section of the report was accepted.

REPORT ON THE STUDENT A.M.A.

"The Student A.M.A. has proved itself as a body of importance to the future of American medicine. Its value has been recognized in many ways, and it is the suggestion of the Council that the Wisconsin chapters at Marquette and the University of Wisconsin designate non-voting representatives to attend sessions of the House, its reference committees, and other events at the time of the Annual Meeting, in a manner similar to that which exists at the clinical and annual meetings of the A.M.A.

"It is expected, of course, that such representatives will bring to the chapters in Wisconsin the actions of the House of Delegates and the reasons for such actions, so that the members of these chapters will become acquainted with the programs and activities of our Society. The House of Delegates should be proud to extend a cordial welcome and invitation to the Student A.M.A., and it is the recommendation of your reference committee that this House record itself as instructing the secretary's office to so advise the two Wisconsin chapters during the ensuing years."

On motion of Doctor Simenstad, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

On motion of Doctor Simenstad, seconded by Dr. D. N. Goldstein, Kenosha, carried, the report, as a whole, was adopted.

Introduction of Guests

Speaker Forkin introduced Dr. Paul Crimm, president of the Indiana State Medical Society, and Dr. Willis I. Lewis, president of the Illinois State Medical Society, who were present at this session.

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Dr. H. E. Kasten, chairman, presented the report of this reference committee which was composed of himself and Drs. T. W. Tormey, Jr., Madison; S. W. Hollenbeck, Milwaukee; S. D. Beebe, Sparta; and J. D. Leahy, Park Falls.

Reports considered by the committee were printed in the Delegates Handbook, as well as introduced in the House of Delegates through supplementary reports.

RESOLUTION ON SECTION ON MEDICAL HISTORY

(Accepted by Council in February, 1953, as an interim action, to be immediately effective and to be submitted to the House of Delegates for ratification.)

WHEREAS, the Council of the State Medical Society has expressed interest in the development of a special voluntary membership classification of the State Society for the purpose of supervising and directing programs and projects in the field of medical history,

THEREFORE, BE IT RESOLVED, that the following amendment to the By-Laws of the State Medical Society be approved by the Council and submitted to the House of Delegates for approval at its first meeting. This By-Law shall be numbered Chapter XII, with subsequent Chapters numbered accordingly.

Section on Medical History

Chapter XII. Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

The reference committee recommended adoption of the proposed By-Law.

On motion of Doctor Kasten, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

RESOLUTION TO ELIMINATE CITIZENSHIP AS A REQUIREMENT FOR MEMBERSHIP

WHEREAS, under the laws relating to licensure of physicians in Wisconsin, citizenship is not required, and

WHEREAS, under provisions of Chapter XI, Section 3 of the By-Laws, citizenship is a requirement for membership in the State Medical Society,

THEREFORE, BE IT RESOLVED, that Chapter XI, Section 3 of the By-Laws be amended to strike from its second sentence the words "who is a citizen of the United States and" so that it would then read: "Every reputable and legally qualified physician who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating."

The reference committee noted that the Wisconsin law does not require that a physician be a citizen, but merely that he has declared his intent to become a citizen. It was believed that each county medical society should be permitted to determine for itself whether it wishes to elect to membership a physician who has been licensed, but who has not attained the status of a full citizen. The reference committee recommended adoption of the amendment.

On motion of Doctor Kasten, seconded by Dr. A. T. Smedal, Stoughton, carried, this section of the report was accepted.

RESOLUTION ON LICENSE REVOCATION AND MEMBERSHIP STATUS

WHEREAS, Chapter XI, Section 3, of the By-Laws contains a provision reading, "A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation," and

WHEREAS, that provision was enacted prior to a change in the Wisconsin Statutes permitting the suspension of a physician's license, and there appears to be no provision regarding automatic revocation of membership upon suspension of a license to practice,

THEREFORE, BE IT RESOLVED, that Chapter XI, Section 3, of the By-Laws, second paragraph, be amended as follows: (New material is italicized.) "A member of a component society whose license has been revoked *or suspended* shall be dropped from membership automatically as of the date of revocation *or suspension.*

The reference committee recommended adoption of this amendment, and on motion of Doctor Kasten, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

RESOLUTION ABOLISHING TIME LIMIT FOR SPEAKERS

WHEREAS, Chapter II, Section 2 of the By-Laws reads as follows:

> "No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time."

WHEREAS, it is the opinion of the Council on Scientific Work, concurred in by the general Council, that this section is obsolete and needs revision, as it does not permit the Council on Scientific Work to grant to a *Wisconsin* speaker more than 20 minutes, regardless of whether his appearance is on the general program or section programs,

THEREFORE, BE IT RESOLVED, that Chapter II, Section 2 of the By-Laws be abolished, and Section 3 of that Chapter be renumbered Section 2.

The reference committee recommended adoption of the amendment, and on motion of Doctor Kasten, seconded by Dr. H. J. Kief, Fond du Lac, carried, this section of the report was accepted.

RESOLUTION TO PROVIDE FOR EDUCATIONAL MEMBERSHIPS

WHEREAS, there are physicians in Wisconsin engaged full time in the teaching of the basic sciences or in other full-time teaching activities, and

WHEREAS, the earned income of these physicians is seldom comparable to that of the practicing physicians and does not afford the ultimate potential of private practice, and

WHEREAS, some such physicians, while retaining membership, feel that the payment of dues in the amount charged those in the full-time practice of medicine is too severe a financial burden, and others state that they are not members because of that burden, and

WHEREAS, it is to the public health advantage of the people of Wisconsin and to the good of the profession that these physicians be associated with their brethren in the professional organizations of medicine and surgery,

NOW THEREFORE BE IT RESOLVED, that Chapter VIII, Section 5 of the By-Laws be created as follows (subsequent sections to be renumbered), such amendment to take effect on January 1, 1954, with prior notification being provided all secretaries of county medical societies:

Educational Memberships. Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

The reference committee pointed out that this proposal would permit those physicians engaged solely in educational and research activities to affiliate with the State Medical Society on payment of dues lower than those paid by men in active practice. This privilege would be granted on the basis that payment of full dues would constitute a financial hardship to physicians in such positions. The American Medical Association would entirely waive its dues for these physicians. Individual counties would determine their own county dues.

The reference committee recommended adoption of this amendment, and on motion of Doctor Kasten, seconded by Dr. D. N. Goldstein, carried, this section of the report was accepted.

REPORT ON THE BRICKER RESOLUTION

The reference committee, after considering this matter at length, stated its belief that this subject was one which must be handled through the Council, which is in frequent session and is the executive body of the House of Delegates. This would provide greater flexibility and would permit the specifics, as well as the generalities, to be considered on any occasion.

On motion of Doctor Kasten, seconded by Dr. W. D. Stovall, Jr., Brodhead, this section of the report was accepted. (See further action in second and third session.)

GENERAL REPORT OF THE COUNCIL

The reference committee reported that it was encouraging and refreshing to note that a number of physicians appear to be following the work of this Society with interest and with a full desire to be a helpful source of information to the membership in their communities. A number of questions had been asked concerning the proposed new building, and the committee emphasized that the new building was not proposed as a matter of convenience, but as a matter of necessity, arising out of the fact that the State Medical Society of Wisconsin is an active, full-blown organization, with several "going" businesses on its hands, as well as activities of great importance in scientific medicine.

Doctor Kasten moved the commendation of the House to the Council for its detailed reporting, not only as to the building but as to all Society activities. He stated that there need be no misinformed or no uninformed member of the Society. When misinformation or lack of information exists, it is because of failure of the physician to avail himself of the *Wisconsin Medical Journal*, the reports of various officers, committees, and staff, which are made repeatedly to the entire membership.

On motion of Doctor Kasten, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this section of the report was accepted.

REPORT OF THE COMMISSION ON PREPAID PLANS

The reference committee was of the opinion that the report of this Commission was fully informative and recommended adoption of the report.

On motion of Doctor Kasten, seconded by Dr. A. A. Quisling, Madison, carried, this section of the report was accepted.

REPORT ON SECTION DELEGATE REPRESENTATION

At the Annual Meeting in 1952, the Council submitted a special report on the subject of Sections and delegate representation. It was pointed out that in the late thirties, Chapter XII of the By-Laws was enacted to provide a mechanism for the formal recognition of Sections, in connection with proceedings of the House of Delegates.

Since enactment of that By-Law, 10 Sections have been created; and the Council commented in its special report that the mechanism for election of delegates has always been vague, and that on some occasions, specialty societies actually had taken over this function.

Through a special committee studying the matter, the Council recommended that Section delegates be without the right to vote but have all other privi-

leges accorded delegates; and it expressed the opinion that this would assure that the House would continue as a democratic organization of all physicians regardless of their general or specialty practice, as those physicians are grouped in their county medical societies.

The Reference Committee on Resolutions and Amendments recommended that the special report be made the subject of further study by this special committee of the House of Delegates. The committee has examined into practices in other states and finds that among the 44 surveyed, only two have Section delegate representation in the House of Delegates,—New York, with such delegates having the right to vote; and Vermont, with such delegates possessing no voting privileges. Of course, the American Medical Association has substantial representation based on Section organization.

Individual delegates, representing Sections, have been contacted for their opinion. There appears to be no particular unanimity of opinion although there was expression to the effect that representation without voting rights would be somewhat meaningless. Several Sections have expressed opposition to the recommendation of the Council itself, but no reasons have been transmitted to this committee.

The committee has considered various alternative mechanisms but does feel it important to recognize the fact that Section delegate representation has been a recognized pattern in Wisconsin for more than 15 years. It is an accepted tradition; and there has been no development supporting a conclusion that this mechanism is without value or that it has upset the democratic organization of medicine in any fashion.

However, it does represent a departure from the philosophy that the component county medical societies constitute the State Medical Society, in that it treats a Section on a somewhat comparable basis as a component county medical organization. If formal Sections continue to be organized, and particularly in those cases in which but a very small group of physicians are concerned with a specialty, county medical society representation would tend to become less effective in the organization of the State Medical Society.

The committee believes, and recommends to the House, that a simple statement of policy should be adopted at this time, as a guide to the physicians who may subsequently be interested in the development of a new Section, and as a statement of policy to which the staff may refer when inquiries are received by it.

Such statement is recommended as follows:

The House of Delegates in formal session in October, 1953, considered the matter of Section organization with delegate representation in the State Medical Society of Wisconsin. The House recognized that as of that date, there were 10 such Sections and that if Sections were to be created indiscriminately, a revision would ultimately be necessitated; for the basic organization is through component county medical societies, entitled to delegate representation on the basis of number of members.

The House of Delegates did not see fit to make such revision at the time it considered this matter, but cautioned future meetings of the House of Delegates to carefully consider the advisability of a Section when petition or recommendation may be filed with it.

It instructed the Council and members to make this recommendation known to the point that future Section proposals will consider the actual necessity of such a group having a delegate, and further, whether such group is of such size, or its problem of such consequence, that special delegate representation should be accorded it.

The reference committee recommended approval of this report, and on motion of Doctor Kasten, seconded by Dr. T. A. Leonard, Madison, carried, this section of the report was accepted.

REPORT OF THE VETERANS MEDICAL SERVICE AGENCY

The reference committee noted that the Agency appeared to be functioning well and recommended acceptance of its report. On motion of Doctor Kasten, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this portion of the report was accepted.

DUES FOR 1954

The reference committee recommended that dues for 1954 be continued at $60, and on motion of Doctor Kasten, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this section of the report was accepted.

INFORMATIONAL REPORT TO THE MEMBERS

The reference committee further reported upon the conduct of Society affairs and the fact that there had been made available to the committee information concerning future planning. Its report included the following statement:

"The real basis for the organization of any voluntary association of a public-spirited nature lies in a two-fold purpose: First, the interchange of scientific information, that each member of the profession may be a better member of the profession and thus better serve the public. Second, that through the strength of association, programs may be conducted impossible to an individual or to small groups. Yesterday you heard of many of these projects. Several of them are of more than usual importance.

"The financial structure of the State Medical Society holds no greater purchasing power in 1953 than it held in 1942. Let each member of the House fully appreciate that what the Society produces is not a 'product' but a series of services to public and profession alike. These services have been found essential and valuable. New ones have been imposed upon the administrative staff year after year, without consideration of the physical facilities necessary to carry on a job which we, as physicians, direct be done.

"There is some feeling among those physicians whose membership interest is casual that the dues are 'too high.'

"As the secretary remarked before the reference committee, he felt that there was no reason why professional dues should not be elevated to the status accorded dues in social and similar organizations. Yet, there seems to be a disposition on the part of too many physicians to protest their dues to their own professional organization, in complete disregard of what that organization is doing for them. But it is, of course, those who are not active and who do not permit themselves to be informed, who compose this category.

"In conference with the administrative staff, it is proposed that some cost accounting procedures be instituted, to the point that special services may be the subject of special billing. If we, as physicians, desire the facility of a Grievance Committee, we, as physicians, cannot expect to create it and not implement it.

"If 1,900 members of our Society desire to participate in a group insurance program at savings equal to the dues they pay their State Medical Society, there would appear to be no reason why each of those 1,900 physicians should not contribute to the State Society its administrative cost in handling disputed claims, keeping enrollment levels, and providing Society facilities in other respects.

"These are illustrative, and point to the possibility of our dues structure in future years being developed on a new basis, namely, requiring all members to pay a certain amount of stated dues as representing the cost of an entire Society function, and then, for special purposes that may exist at a given time, requiring that those physicians who participate in it provide such nominal reimbursement as may be necessary for administration of that particular project."

FURTHER ACTION ON BRICKER RESOLUTION

Dr. J. M. Beffel of Wauwatosa arose to point out that the action of the House of Delegates with regard to the Bricker resolution had been to refer the matter to the Council with no recommendation from the House of Delegates as to its stand on the subject. He expressed his personal opinion that, as a medical organization, the Society should not issue an official statement on an international situation which is still under discussion by the Congress. As individuals, physicians have that privilege, and could express their opinions to their Congressmen.

Doctor Beffel offered a motion that the House recommend to the Council that the resolution concerning the Bricker resolution be tabled. The motion was seconded by Dr. E. C. Cary, Reedsville, and by a rising vote, was carried by a vote of 40 to 18.

On motion of Doctor Kasten, seconded by Dr. W. D. Stovall, Jr., carried, the report of the Reference Committee on Resolutions and Amendments was adopted as a whole, as amended.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Committee reports published in the Delegates Handbook as well as supplementary reports presented to the House of Delegates were considered by this committee as referred to it by the Speaker.

Dr. G. W. Carlson of Appleton, its chairman, reported in behalf of the other committee members, Drs. C. A. H. Fortier, Milwaukee; N. A. Eidsmoe, Rice Lake; C. W. Stoops, Jr., Madison; and Charles W. Giesen, Superior.

Doctor Carlson stated that the committee was impressed with the great amount of time and effort that had been devoted by busy doctors all over the state to a positive and forward approach to the problems at hand, and the reference committee wished to commend them for the excellent work being done.

The reference committee further commended the headquarters staff for its excellent help in carrying out the programs of the committees of the Society, and felt that the Society should express its gratitude to the many agencies and lay individuals devoted to furthering good public health.

The reference committee emphasized that it is most important for each delegate to take back to his county society the information contained in the Delegates Handbook, as well as in supplementary reports presented. The committee specifically urged each county society to act on matters referred to it, and to do so at an early meeting devoted entirely to these matters.

COMMITTEE ON CANCER

A. R. Curreri, chairman; W. S. Bump; D. C. Beebe; S. L. Henke; A. C. Taylor; R. P. Welbourne; P. B. Blanchard; W. E. Bargholtz; J. W. Conklin; G. C. Schulte; K. G. Pinegar; James E. Conley; R. B. Larsen

The Committee on Cancer has continued to function primarily as the Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society. As such, it has assisted in the development of projects in professional education and the training of technicians in exfoliative cytology, and has reviewed and recommended financial support for specific research projects at McArdle Institute.

Professional Education

For the past several years the cancer education program has been coordinated with the general professional education programs conducted under the auspices of the Coordinating Committee on Postgraduate Education. As such, many topics related to cancer have been presented. However, it has been felt by members of the Committee on Cancer that in addition there should be periodic meetings of a clinical character devoted solely to the subject of cancer.

Therefore, during the past year the professional education committee has arranged for three clinical conferences to be held the latter part of October in Eau Claire, Wausau, and Appleton. Local committees are securing patients for case study, and the general subjects to be covered are those of lung cancer, oral lesions, uterine cancer, and cytologic examinations.

In an effort to extend its professional program to allied groups these meetings are being planned so that they will attract dentists, as well as doctors; and a portion of the clinical conference and the evening program is being devoted to lesions of the oral cavity. It is felt that such interprofessional meetings have value, not only in terms of scientific inquiry, but also in good public relations.

Efforts have been made to provide special cancer programs for hospital staff meetings, but to date this phase of the professional education program has not been developed adequately and needs further organization. It is anticipated that during the coming year such programs can be arranged in many of Wisconsin's hospitals, with speakers provided by the Wisconsin Division of the American Cancer Society and patients or case studies provided by the local hospital staff.

Training of Laboratory Technicians

Extension of laboratory services by technicians trained in cytologic examinations seems desirable and can be coordinated with services of the State Laboratory of Hygiene so that more adequate cancer control can be achieved. The training of technicians will require funds for scholarships, an organized teaching program at the State Laboratory of Hygiene, and proper supervision by qualified pathologists in local hospitals. During the current year a study of the subject has been made by the Committee on Cancer, through its professional education committee, and in cooperation with both the Milwaukee and the Wisconsin Divisions of the American Cancer Society, and the State Laboratory of Hygiene, such a program is to be initiated during the ensuing year.

Public Education and Services

While the Committee on Cancer has concerned itself primarily with scientific matters, it has also served in an advisory capacity on several projects concerned with public education and services. Basic policies in respect to the dressings program have been reviewed and approved by the committee and have become the official policies of the Wisconsin Division of the American Cancer Society. These policies set forth accepted procedures for the securing of dressings for cancer patients and ways in which they can be used properly.

A year ago the Committee on Cancer prepared a simple leaflet on "What You Can Expect of a Cancer Examination" for distribution to the public through doctors' offices and other avenues. More than 300,000 of these leaflets have been used and have contributed to a better understanding of what logically can be expected in a physical examination and its means of detecting cancer at an early stage. Many doctors have commented favorably upon this leaflet as a sane approach to an important problem in physician-patient relations. Encouraged by the acceptance of this leaflet the committee has prepared a second folder entitled "If Your MD Suggests a Smear or Biopsy," which is to provide proper understanding of procedures commonly employed for detection of cancer. It is hoped that physicians will make extensive use of this leaflet as a means of advancing proper public education and avoiding the development of false concepts of accepted procedures used by physicians.

Research

Cancer research in Wisconsin, through McArdle Institute, is making a significant contribution to the over-all understanding of the abnormal growth of cells and the development of malignancy. While the research at McArdle Institute is partially supported by special grants from the American Cancer Society, through the coordinated research under the direction of the Committee on Growth, there are special research projects at McArdle being supported by direct grants from the Wisconsin Division of the American Cancer Society. (Part of the research is being interpreted as a scientific exhibit at the 1953 meeting, and all delegates are urged to view the display and attain a better understanding of the way funds of the Wisconsin Division of the American Cancer Society are being invested, under the supervision of the Committee on Cancer.) An annual grant of $18,000 is provided for special research projects, and this past year an additional grant of $7,000 was provided to support a special research project on the "Cause of Bladder Cancer."

Recommendations

1. Hospital staffs set aside one meeting per year for an intensified study of cancer, with speakers furnished by the Wisconsin Division of the American Cancer Society and case studies provided by the local staff.

2. Those communities served by a qualified pathologist avail themselves of the opportunities of establishing special laboratory services in cytologic examinations.

3. County medical societies take a more active interest in the cancer education program by appointing at least one interested physician who can and will work with the Committee on Cancer in local interpretation of professional and lay education programs. Such appointments be made and the names transmitted to the chairman of the Committee on Cancer, so that an effective state-wide professional group can be developed to carry on an expanded and intensified cancer control program in Wisconsin.

The reference committee recommended adoption of the report with emphasis on the need for more active organization on the county and hospital staff level, to afford liaison with the Committee on Cancer and to provide avenues through which intensified professional education can be secured through the assistance of the Wisconsin and Milwaukee Divisions of the American Cancer Society.

On motion of Doctor Carlson, seconded by Dr. A. T. Smedal, Stoughton, carried, this section of the report was accepted.

COMMITTEE ON GRIEVANCES

R. E. Fitzgerald, chairman; E. W. Mason; F. A. Nause; C. E. Zellmer; E. D. Sorenson; H. W. Wirka

Introduction

In the past five years the medical profession has further developed its responsibility in providing the Grievance Committee as a facility to which the public may bring its problems, its complaints, and its general "gripes" concerning sometimes an individual physician, or physicians as a profession, or a situation in a particular area.

To give a statistical report would divert the attention of the House of Delegates from the real purpose the members of this committee hope to achieve; for such a report, in itself, would indicate that matters are in quite good shape. The committee is fully appreciative, however, that the number of matters referred to it (35 in the first six months of 1953) cannot be viewed as the total test. Some matters are handled by county medical societies. Others are never reported, and some are simply routed elsewhere with nothing being done about them.

Wisconsin's population is nearly three and a half million persons, with 2,800 physicians in private practice. The total yearly contact between physician and patient must be counted in the millions. In the physician's daily contact with the sick he is necessarily confronted with emotional stress and deep personal concern,—the perfect culture in which to breed possible misunderstanding and dissatisfaction. The committee cannot do other than reach the conclusion that criticism of specific matters, expressed and unexpressed, is insignificant when viewed in light of all these circumstances.

Then too, to discuss specific matters handled by the committee would also divert the House of Delegates from the purpose of this report. No factual circumstance of an individual situation can be presented unless it is presented in its entirety; and the committee report would then necessarily become bulky, and while doubtless interesting and provocative of discussion, consideration would be given to the details rather than to the principle.

Over the period of time in which it has been in existence, the committee has gained certain impressions and has reached certain conclusions. This is not so much an annual report as it is one covering committee activity and the committee's recommendations with respect to its general impressions.

The New Practitioner

Probably there has been no comparable time in the history of our nation when its youth has been confronted with so many obstacles and uncertainties in its own planning for the future. This is particularly true of those who pursue medical education and ultimately secure medical licensure.

The science of medicine has become complex in almost geometric proportion to its expansion. The demands of the public, arising out of military needs, increased knowledge of the value of medical care, as well as many other matters, have brought about a marked increase in the numbers being educated.

The student is confronted with a period of intense training, almost to the point of excluding adequate time for relaxation and the pursuit of cultural knowledge. He is so busy learning facts and science that he has little opportunity to develop philosophy and practical experience. He knows that his education is expensive. He knows that in all probability he will enter military service. There are some who plan to seek specialty training, involving as much as an additional five years of postgraduate education.

All of this means that those who enter general or specialty practice have devoted a number of years to being technically educated, plus the additional time of military service. It is a natural psychological reaction that upon their "at long last" entering into private practice, these individuals will pursue as rapidly as possible the achievement of their individual ambitions.

During these long years of preparation, the art of medicine has not been effectively emphasized. Most certainly it is a part of the problem of medical education. Yet, medical education can only quickly touch upon it in formal manner and hope that by some process of osmosis, a sense of the art of medicine will be acquired during the days of formal training.

The inevitable conclusion is that if the medical profession exercises its full responsibility, it must assist in conveying to the new practitioner, as best it can, the importance of knowing what constitutes the art of medical practice. This is an intangible subject in itself. It means the proper handling of the patient as an individual and not as a case number in the medical records of an office. It means knowing the patient as a person and some of those problems of concern to him that bear upon his medical treatment, such as costs, implications of medical findings to future earning power, and advice in handling problems that any extensive period of medical care may create within the family.

The realm of medical responsibility is beyond the strict margin of duty itself. Consequential charges cannot be arbitrary and without explanation. The practitioner's availability to the area which he seeks to serve must be realistic and cannot be measured by careful adherence to office hours, a 40-hour week, vacation patterns possible within other groups, and the social and professional ostracism of his people. He must be patient with the worried and sometimes frustrated individual. He must recognize that his time in actual patient contact is not, in itself, illustrative of the work that goes into serving his patient; for study, laboratory tests, x-ray readings, and many other time-consuming procedures are known to most patients only by their end result.

As far as others in the profession are concerned, the physician's competence is demonstrated by performance and not by license. The physician must develop tolerance and, upon first entering into practice, recognize that he does so as part of a large fraternity with a common purpose. He must help

his profession when that help is needed, and he must participate in its economic, as well as its scientific activities.

The committee observes that there is the occasional new practitioner who tends to become isolated socially and professionally from his brethren in practice. He becomes too competitive under the pressures of establishing his family and himself on a sound financial basis. He seeks to apply routines of personal plans, rather than routines necessary to properly serve patient needs; and in doing so, he brings upon himself, as well as others in the profession, criticism that carefully analyzed indicates that he is thought of as impersonal and even indifferent. He creates the impression that he is less of a human and more of a robot and because he is a member of the medical profession, the impressions that he creates for himself are transferred to the entire profession. It is clearly a responsibility of the entire profession to encourage, advise, and work with the new practitioner so as to inculcate in him the proper concepts of a medical practice.

Recommendations

1. Each county medical society assign to a specified group within its organization the responsibility of greeting new arrivals in medical practice to discuss the community, its problems, and to offer assistance in consulting with the new practitioner from time to time relative to his own problems in establishing his practice.

2. Upon acceptance of his application for staff privilege, the physician be formally welcomed to practice in the hospital through introduction at the staff meeting to other staff members.

3. Upon application and acceptance into membership in the appropriate county medical society, its officials notify the newspapers.

4. To the extent possible and practical, new physicians be acquainted with activities of the society through assignment to a working committee of the local organization, possibly in some limited capacity.

* * * *

The Established Practitioner

Here the committee is impressed with other problems, and as to this practitioner, as well as to all practitioners, the committee again emphasizes that its report, its impressions, and its recommendations are intended to alleviate a situation which does exist, but which should not by any means be attributed to every physician. It emphasizes again that a situation which causes public criticism and resentment tends to develop to the point of affecting all of the practitioners in the community, even though practically all of them may conduct themselves in such a manner as to reflect great credit upon themselves as individuals.

The longer a man engages in practice, the more he tends to become wedded to certain ways. His own judgment as to what to do in a given situation may tend to follow a certain pattern. Yet, there may be optional mechanisms, and the judgment of one physician may not necessarily be the judgment of another. The words "always" and "never" should be eliminated from medical terminology. "I always do thus and so," made as an offhand statement in the presence of members of the general public, who may not be patients of that physician, may raise doubt as to the adequacy of treatment rendered by their own physician.

The accent in sentence structure is fully as important as its punctuation. If a patient presents himself to a physician, and it is obvious that he has had prior medical care, and an inquiry is made and properly so, care should be given not to place special accent on the word "who." Take, for example, the sentence, "Who put that cast on your arm?" Let the reader of this report say that aloud with somewhat more than usual accent on the word "who." The implication is obvious.

Then, there are those occasions which sadden every physician when, despite all the application of scientific knowledge and skill, a patient, who should yet have a period of usefulness, passes on to his final reward. No physician worthy of his heritage can but reflect upon many of these situations, examine into his course of treatment, and pause to consider in his own mind whether there was anything else he might have done.

Physicians must also appreciate that such periods of reflection exist on the part of the bereaved family. Not infrequently, individuals with such a concern seek reassurance of the physician at a time when he is busy with his current problems of waiting patients. It seems to this committee that every physician should make a special effort to talk with these individuals when he is not under the press of immediate practice, rather than see them at times when he cannot, in good conscience to those who need his immediate care, delay while he consoles those who need his assurance and explanation. Physicians should greet such individuals cordially and arrange a special time to meet with them.

As this committee has engaged upon review of case after case, it recognizes that a weakness of the physician is the fact that he is human; and the general desires and ambitions of the human race are expressed as much by a physician as by any other individual. He likes and deserves his afternoon "off" during the course of the week, perhaps in order to secure needed relaxation or to engage upon his paper work, or simply to rest.

In larger communities a common day, when the physician does not open his office, becomes the practice among all practitioners. All the physicians, for example, may take Thursday afternoon as a "free" afternoon, in some communities simply to balance the fact that they maintain evening hours on that same or prior day. But these situations sometimes bring about community complaints, often not expressed to the physicians themselves, because after all, most people are considerate and hesitate to pass along a comment which they are afraid will unwittingly offend an individual or individuals whom they respect and admire.

Turning to a different matter, there are occassions in which an attending physician should himself seek consultation, even though his patients appear to be completely satisfied. Consultation is assurance to the practitioner and the patient alike. It should be re-emphasized that it is a responsibilty of all to help another in a particular problem. That is part of the spirit of a profession which is organized in the philosophy of a fraternity.

Then too, on occasions, situations have come before this committee in which one physician, certainly without intent, creates a difficult problem for another who may in some fashion later become associated with the case. As a miscellaneous example, problems are unnecessarily created in referral of a patient for surgical attention and creating in the mind of the patient that the surgery is inconsequential, when that fact cannot always be prophesied with accuracy, or passing along some comment to the effect that the cost will be nominal when again that cannot be determined by any rule of thumb.

Overcharging might more often be characterized in light of this committee's experience as underexplaining. Substantial bills need explanation. Prudent individuals,—even physicians themselves,—ask estimates of costs that may be encountered in the repair of an automobile, in construction or repair of a home, and similar matters. Why is not the patient entitled to do so? More than that, why should not the patient receive a physician's volunteered judgment as to what consequential future treatment will mean by way of out-of-pocket expense? A bill in some detail, while perhaps time-consuming, is far better than a dissatisfied patient.

These and other reactions could be stated; but they would all lead to the same conclusion,—the relationship of the established practitioner with his patient must be as personal as possible.

Recommendations

1. County medical societies should undertake consideration of this portion of the report with a view of developing community practices which will achieve better public relations in every medical community in Wisconsin.

2. The House of Delegates instruct the preparation of pamphlets available for patient distribution on a take-home basis, discussing some of the more common problems the patient encounters at the time of extensive medical care.

3. Each county medical society hold at least one meeting a year to discuss trends in patterns in local medical practice and to assure free and open discussion in the area, and each physician be asked, prior to such meeting, to suggest any matter which he feels advisable for general consideration.

* * * *

The Older Practitioner

There comes a time which all of us anticipate, sometimes with pleasure and sometimes with apprehension, when practice becomes less active, when physical needs demand less rigorous hours and routines. Retirement often comes about as a gradual process. No one who has ever been active can fully accustom himself to that change. He feels somewhat lonesome or at a loss at times. He is concerned that his suggestions may be considered by some of his fellow practitioners as out of date and unrealistic. Yet, he retains to the degree possible his contacts with the public. His advice may more often be gratuitous as patient pressure relaxes, and gratuitous advice is a problem with which any medical practitioner is confronted in his daily social contacts.

No one can easily give up that which he loves. In an endeavor to remain active to the best of his ability, he fails to appreciate that without association with others in practice, his restricted practice, in itself, creates misimpressions.

The committee can arrive at no concrete recommendation. It recognizes these physicians as performing invaluable service. It recognizes the personal sacrifice which these physicians make in their concern that a community will suffer by their complete retirement from practice. To these physicians is owed a great debt of gratitude for the manner in which they come to the front in times of great national concern.

But the committee does emphasize that an association with another physician, either formal or informal, is most necessary when the physician has reached that point where some restrictions become necessary in his own health interest.

The solo practitioner should endeavor to advise his patients whom to consult when he is unavailable, particularly if he must conserve his energies to remain a useful and productive citizen.

Conclusion

The committee is fully appreciative that its report is more of an editorial than it is a report of its activities. It has been a satisfaction to the committee to handle its work. The overwhelming percentage of cases that have come before it have been satisfied by the committee in cooperation with the physician, patient, and others concerned; for it has been the committee's policy to provide a full hearing to those who may be concerned with a particular problem and to secure in as great detail as possible such facts as will enable the committee to arrive at an equitable conclusion.

There have been few cases in which the committee's objective has not been completely satisfied. If greater effort is exerted on the part of the entire profession as a result of this report, the committee will feel that another phase of its objectives will have become realized.

There are but two further matters.

1. Amend Chapter VII, Section 5 of the By-Laws to increase the committee membership from six to nine so that there may be greater geographic representation on the committee, and at the same time, make it easier for a physician to serve on this committee under a mechanism that permits a quorum with four absent, rather than as at present, a quorum with two absent.

2. The committee recognizes the impact of its activities upon the staff. Many of these cases are complex, and in order to ascertain the facts, secure the appropriate records, interview the individual concerned, and a multitude of other details, the staff has been required to absorb an administrative function that is extremely time-consuming.

If this committee activity is to be retained and if it is to be handled in effective discharge of the responsibility assumed, some arrangement must be made so that the committee may be adequately staffed without undue strain upon the Society's administrative group.

Therefore, the committee proposes, with approval of the House of Delegates, to do an actual cost accounting of all its activities from the period of November 1, 1953, to June 30, 1954, for House of Delegates consideration in the fall of that year.

The reference committee agreed with all recommendations of the Committee on Grievances and urged that the report be separately distributed to the new members of the Society during the next few years. It also asked that a letter be sent to secretaries of county medical societies recommending that this report receive special consideration at an ensuing business meeting, and noted that the committee had asked that the By-Laws be amended to increase its membership from six to nine.

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Madison, carried, this section of the report was accepted.

COMMITTEE ON HOSPITAL RELATIONS

Karl H. Doege, chairman; A. H. Barr; S. R. Beatty; Gorton Ritchie; W. B. Hildebrand; O. V. Overton

The Committee on Hospital Relations has been on a "stand-by" basis during the past year, ready to adjudicate any specific complaint on the part of hospitals or physicians directly concerned with contractual relationships in the fields of pathology, radiology, or anesthesiology. Some discussion has been directed to the dissolution of the committee, but the consensus of those queried indicated the desirability of maintaining the committee in event any specific complaints should occur from specialists most directly concerned with services in the hospitals.

During the past year a survey was made of all Wisconsin hospitals to determine the extent of services in radiology and pathology, what communities felt in need of additional service, and to what extent proper facilities would be provided if either part-time or full-time services could be secured. This survey showed that while many small communities expressed a need for radiologic or pathologic services, few were actually prepared to provide proper facilities, or to offer sufficient case load to work out a practical solution. The findings of this survey have been turned over to the Wisconsin Radiologic Society and the Wisconsin Society of Pathologists with a request to make more intense local studies of areas requesting service, to see if available qualified personnel in neighboring communities could be made available on a part-time basis if proper facilities can be provided.

Recommendations

Inasmuch as the Committee on Hospital Relations will continue to function on a "stand-by" basis, it is recommended that delegates, reporting back to their county medical societies, remind members that the committee stands ready to adjudicate any special problem between members and hospitals, if such problems cannot be solved through regular channels of the county medical society or the specialty group immediately involved in the dispute.

The reference committee recommended adoption of this report, and on motion of Doctor Carlson, seconded by Dr. T. A. Leonard, carried, this portion of the report was accepted.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

T. L. Squier, chairman; A. H. Heidner; Norman Becker; J. W. Boren, Jr.; A. P. Zlatnik; W. S. Middleton and J. S. Hirschboeck, ex officio

This committee met in Madison on June 14, 1953, all members being present. Its report consists of the following minutes of the June 14 meeting.

1. Statistics, Physicians in Wisconsin; IBM Punch Card System

Secretary Crownhart reported that approval had been granted to developing an IBM punch card system to record pertinent information concerning all Wisconsin physicians. This system will become effective January 1, 1954, and will be operated in cooperation with the American Medical Association. The following information will be shown and may be tabulated in any combination:

- Physician's full name and address
- Date of birth
- Sex
- Medical school
- Type of practice: private, institutional, etc.
- Specialty by 32 classifications
- American Board certification
- Race and citizenship
- Location by medical service area
- Medical fraternal affiliations
- Size of community in which practicing by 10 different "sizings"
- Membership status

Question 1: Is the information planned sufficient? After discussion, and on motion of Doctors Middleton–Hirschboeck, it was voted that full-time and adjunct staff appointments be included.

There was further discussion, in which the secretary suggested that, if at all possible, the IBM mechanism might show frequencies in change of location. Doctor Hirschboeck suggested that each card show information as to military service and military commitments. Doctor Squier suggested that special effort be made to inventory interns and residents from beginning to end of training and that this be done through hospital questionnaires.

On motion made and seconded it was voted that these suggestions be followed.

After discussion it was agreed that information concerning fraternal affiliations is not necessary in this procedure.

Doctor Hirschboeck pointed out that the Medical Society of Milwaukee County biennially published a directory of members containing much of the information to be maintained in the IBM mechanism. He inquired whether the material gathered by the State Medical Society would suffice for such a purpose.

Following discussion it was agreed that the secretary would advise the Milwaukee Society of the project and ascertain if further information would be helpful to it in such manner that it could secure IBM tabulating runs for the purpose of its directory.

Question 2: How frequently should statistical surveys be conducted and results analyzed and published?

Following discussion, and on suggestion of Doctor Middleton, it was agreed that surveys be conducted each year for the first five years, and biennially thereafter, unless need indicated otherwise.

2. Placement Service of the State Medical Society

Details of this program were reviewed by the committee. In summary, physicians advising of interest in Wisconsin location are requested to file a comprehensive report giving details of medical education, previous locations, field of particular interest, type of community and practice in which interested, and references.

Communities and individuals seeking physicians are requested to provide the Society with detailed information of importance to physicians and families, including information as to present medical service, hospital facilities, home and office availability, educational institutions, and other matters.

A representative of the state office attends meetings of the State Board of Medical Examiners to meet with prospective licensees and provide information to those not yet settled on a Wisconsin location.

The *Wisconsin Medical Journal* provides a procedure so that those who wish physician assistance need not identify themselves, and those physicians desiring locations may preserve that information as confidential.

It was reported that all agencies cooperate with the State Medical Society in this effort. The American Medical Association advises the State Society of information it has concerning physicians interested in Wisconsin locations. Both the State Board of Medical Examiners and the State Board of Health provide similar information, and, in turn, the State Medical Society provides assistance to state agencies and other governmental bodies when requested.

Following discussion it was agreed without motion that the project be continued, and on suggestion of Doctor Middleton it was further agreed that inquiry to communities include questions designed to ascertain whether the particular community had any specific project or contribution under way specifically designed to induce physician interest and assurance of community cooperation.

3. Distribution, Adequacy and Availability—Physicians in Practice

After general discussion and review of past activity in this field, on motion of Doctors Zlatnik–Boren it was voted that three pilot studies be conducted by the staff in areas 15 miles in radius of centers to be determined from requests filed in the state office.

It was agreed that procedures used and information to be assembled be first submitted to the committee for its approval.

It was agreed that the county societies in the areas involved be advised of the project before it is undertaken.

It was agreed that a fourth project be a detailed study of an effort of some community already successful in securing medical assistance, and that the physicians so locating be interviewed for their reactions, the problems encountered, and the success with which those problems have been met.

It was agreed that among other matters to be included in such studies, there be the following:

- Population and population characteristics
- Extent of present service, including part-time services
- Extent of needed service
- Transportation and communication
- Other health services and facilities
- Number of other types of practitioners
- Community economics
- Hospitals, availability and staff
- Police services, including ambulance
- Education and housing

It was agreed that the committee inform itself on the physician needs of state institutions and state departments and bureaus. The secretary was authorized to arrange the next meeting, preferably on July 30, so that the director of the State Department of Public Welfare, Mr. Tramburg, and the state health officer, Doctor Neupert, might be present and provide the committee with information on this phase of physician distribution and availability.

4. Brochure on Wisconsin and its Medical Facilities

Mr. Thayer, director of public information, recommended the preparation of information for interested physicians detailing medical and other facilities of the state as a whole, in addition to information on a specific community. He recommended that among this material should be included:

- A map of the state, showing hospital location
- A map showing population and physician distribution
- Information concerning the state's general educational facilities and location, including the universities, state colleges, and private institutions
- Information relative to graduate and postgraduate medical education
- Information concerning state health agencies and their activities and responsibilities
- Information concerning state and county medical societies, location, officers, emergency call systems, and similar matters

By motion it was agreed that the Society staff should proceed with the compilation of a proposed brochure to be submitted the committee for its review and further recommendations.

5. Preceptorship System in Wisconsin

This subject had been included on the agenda as physicians in the state had expressed interest in the possibility of its expansion by the state university and its adoption by Marquette.

Dean Middleton explained its purpose and history. Dean Hirschboeck indicated Marquette's interest in the matter and the fact that in some respects it had adapted some features of it to the Marquette system.

It was agreed by the committee that the membership of the Society should be advised that the preceptorship system is essentially a very closely integrated part of medical education under the supervision, direction, and responsibility of the schools; the State Medical Society is not and should not be in a position of control or supervision, but it can endorse and assure the deans of cooperation on the part of the profession.

It was agreed that expansion beyond its present point was entirely a prerogative of medical educators, it being understood that should there be a further development of education facilities at the University of Wisconsin there might follow a very limited expansion in number.

6. Financial Support of Medical Education

Following discussion it was agreed that the State Medical Society should endorse the principle of financial support to medical education by private enterprise rather than federal aid.

The reference committee commended the projects of this committee and urged the House to record its approval of the report. On motion of Doctor Carlson, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

COUNCIL ON MEDICAL SERVICE

D. E. Dorchester, chairman; R. L. MacCornack; C. G. Reznichek; T. D. Elbe; L. O. Simenstad; W. J. Fencil; J. S. Devitt; D. N. Goldstein; D. M. Willison

During the past year, the Council on Medical Service has been primarily concerned with an extension of its public relations and health information activities into specific "problem" areas. Thus, major effort has been directed toward projects involving health councils, emergency medical services, nursing education, audio-visual aids in health education, and rural health. These projects are in various stages of progress, some already in operation, some near completion, and others in planning.

PUBLIC RELATIONS

In the field of general public relations, the Council has been concerned with the following important activities during the past year:

Physicians Placement Services

The increasing demands of the military forces of the United States for physicians has placed considerable pressure upon the Physician Placement Service activities of the State Medical Society to provide physicians for the civilian population in Wisconsin. With several years of experience behind it in the physician placement and location field, the Society is becoming more effective as an instrument for arranging adequate medical services for communities in need. This service is not limited to assisting communities seeking the services of a full-time physician, but includes also any assistance the Society may be able to give in obtaining a locum tenens or practicing physician for already-established physicians.

To fulfill its obligation to help physicians seeking locations and to assist communities seeking the services of physicians, the service maintains close contact between the University of Wisconsin Medical School, Marquette University School of Medicine, the American Medical Association's Physician Placement Service, the Armed Forces, and the medical schools and medical associations of neighboring states.

Throughout 1953, there has been an average of about 60 available locations on the monthly list of communities seeking physicians. There have been an equal or greater number of physicians seeking locations. The military situation has accelerated the turnover, as well as the number of communities and physicians seeking assistance at any one time. The Physician Placement Service has been particularly effective in relaying information about desirable Wisconsin locations to physicians about to be released from military service. In several instances, the Placement Service has been instrumental in helping these men to locate in areas which were about to lose their last remaining physician to military service.

In light of the increased competition between states and various services within the state for the physician of today, the Physician Placement Service is cooperating with the Committee on Medical Education and Hospitals in the development of a brochure to explain the opportunities and advantages of locating in Wisconsin. When completed, the brochure will be made available to all out-of-state physicians interested in Wisconsin practice, as well as to others.

Frequently, the Society is called upon to send its officers or staff members to confer with community representatives or to speak at community gatherings where the subject of obtaining a physician is under discussion. These meetings have not only been of assistance to the community in their efforts to obtain a physician, but have often resulted in the establishment of emergency arrangements to handle medical care until a resident physician is found. At the very least, such visits are extremely productive of good will and should be encouraged wherever possible.

Press Conferences

The results of the press conferences of 1952 have been apparent throughout the past year. There is considerable evidence that the day-to-day working relationships between physicians and newsmen have improved as a result of these conferences; and, in fact, the series of meetings held under the sponsorship of the State Medical Society and its county societies have been followed up on the local level

with an encouraging degree of success. During 1953, the Medical Press Conference series was concluded with a meeting of the newspaper, radio, medical, and hospital representatives of Milwaukee County in cooperation with the Medical Society of Milwaukee County. In several instances, county-wide press conferences sponsored by constituent activities during 1953 have resulted in the establishment of informal agreements for the clearing of information on news of accidents or illness. The effect of this relationship is felt in other ways, such as cooperation for the elimination of "quacks" and misleading advertising.

As evidence of the success of the conferences, there has been a noticeable increase in the number of inquiries from newspapers and radio stations concerning such problems as medical ethics, fraudulent and misleading advertising, physician responsibility toward his patient in the event of accident and illness, confidentialness of physician public records, and information about new drugs and treatments.

Health Councils

Members of the Council met with representatives of a special Wisconsin Press Association committee which is anxious to develop a joint program for the promotion of community health through the medium of health councils. It should be recalled that a health council is a voluntary organization of lay and professional people in a community to work for the improvement of local health conditions. Health councils are being encouraged in this state by the Wisconsin Public Health Council in which the State Medical Society has been vitally interested during the past several years. These councils take the lead in establishing school health examination programs, hearing testing programs, cancer detection and education programs, elimination of sewage disposal problems, and the like. The Council has appointed a subcommittee to work with the Wisconsin Press Association in the development of a program for health council promotion with the weekly newspapers of Wisconsin. It is hoped that, as a result of this cooperative effort, the Council and the Wisconsin Press Association will be able to select one or two areas in the state in which to develop and promote a health council program for community health improvement on a trial basis.

Emergency Medical Services

Physicians have traditionally maintained an individual and personal responsibility for the care of their particular patients once these patients have been accepted as such by the physician. During recent years, there have been complaints that the services of physicians are not always available to the public on a twenty-four-hour-a-day, seven-day-a-week basis. For those who have a well-established doctor-patient relationship, emergency care is not usually a problem. However, there are many factors which contribute to situations which have called for the development of "emergency medical services." Among these are greater understanding of health needs on the part of the patient, a trend away from the family doctor relationship and the growth of the so-called "personal physician" relationship, and the possibility that the greater concentration of physicians made possible by improved communication and transportation has contributed to an impression, often unfounded, that the services of a physician are not readily available.

All of these factors have prompted the Council to initiate a survey to determine the extent to which the physicians and hospitals of Wisconsin have made arrangements for the handling of medical cases of an emergency nature at any time of the day or night.

A complete report of this survey will be presented to the Council at its meeting just prior to the House of Delegates session.

4-H Club Program

The Council has continued to expand its relationship with the extension division of the University of Wisconsin and the 4-H Club program in Wisconsin. In the past, the State Medical Society has awarded health achievement certificates to some 30 or 40 4-H Clubs which have been responsible for developing successful community health projects. While the health achievement certificate project was some measure of recognition for the work accomplished, 4-H Club leaders and members of the Council felt that the element of recognition should be combined with a reward of more practical purpose. Accordingly, the Society will annually present to each of 30 or 40 outstanding 4-H Clubs in Wisconsin a one year's subscription to "Today's Health" along with a gift subscription card which will carry the name of the club, the name of the 4-H Club leader to whom it was presented, and the signatures of the president of the State Medical Society and the president of the county medical society in the area in which the club performs its activities.

In addition, the State Medical Society will continue its program of making $100 available annually for the purpose of sponsoring the attendance of 10 or 15 outstanding state 4-H Club leaders at the Wisconsin Health Conference. These leaders constitute a special 4-H Club health project committee which plans the state 4-H Club health program for the ensuing year. At the same time, the State Medical Society provides a $100 scholarship annually to an outstanding 4-H Club boy or girl who has been responsible for family and community health activities during the past year. The winner uses the scholarship to attend the National 4-H Club Convention in Chicago.

Health education materials and speakers for county homemakers' meetings are made available to the extension division and various county 4-H Club groups through this Council. The Council encourages physician participation in the meetings of 4-H Clubs and county homemakers wherever the invitation is extended.

"Your Doctor"

During the past year, the State Medical Society has encouraged commercial theaters to show the American Medical Association film entitled "Your Doctor." This 15-minute documentary film shows how physicians are trained, what the medical profession is doing to improve health standards in the

United States, and how the State Medical Society and the individual physician work for the betterment of health. A large number of Wisconsin theaters have shown the film as have many farm, professional, and civic groups. The Kiwanis, Rotary, and Lions Clubs have publicized the availability of the film in their state bulletins, and PTAs, Farm Bureau groups, county home agents, and the Woman's Auxiliary to the State Medical Society are now being encouraged to show the film to their groups.

Loan Packets

In accordance with instructions from the Council, the staff prepared a loan packet on health insurance for the University Bureau of Information and Program Services to supplement or replace its material on this subject. The University reports that nearly 1,000 requests a year have been made for this packet. In addition, the Society supplies loan packets of materials to literally hundreds of persons, both lay and medical, on a wide variety of health subjects. These requests have not been solicited. Most of the requests relate to the availability and distribution of physicians and hospitals, health insurance, and the cost of medical care.

Program Services

During the past year, a simple brochure was developed for the Woman's Auxiliary to the State Medical Society to be of assistance in planning and scheduling meetings to educate the public on personal health and economic and social aspects of medicine. This manual offers the services of the State Medical Society in providing meetings with speakers, films, exhibits, and pamphlets on the subjects of cancer, heart disease, care of the aged, mental health, school health, nurse recruitment, civil defense, distribution of physicians, medical education, the American Medical Association, and the State Medical Society. This manual has already been influential in the arrangement of a large number of meetings on these subjects.

Medical Associates Brochure

The necessity for more adequate recruitment literature on the subject of the careers available in medicine and related fields has long been apparent to the Council. During the past year, it approved, developed, and distributed a booklet describing the opportunities available in a wide variety of occupations related to the practice of medicine. Included in the pamphlet are descriptions of careers in pharmacy, nursing, medical technology, public health, and the like. The production of this brochure was a joint effort of the State Medical Society, the Wisconsin Hospital Association, and the Medical Society and Hospital Council of Milwaukee County. Copies of the brochure were distributed without charge to all libraries in Wisconsin, all high schools and vocational teachers, most hospitals, each county medical society, and many individuals who made personal requests. The Council is certain that the distribution of this brochure and the publicity which has accompanied it will do much to bring about greater interest in the professions associated with and allied to medicine. Already, Wisconsin vocational guidance people have given this brochure high praise. The Council is hopeful that its distribution and wide use will be a significant contribution to the recruitment of much-needed personnel in the health fields.

MARCH OF MEDICINE

"The March of Medicine" is currently in its eighth consecutive year of broadcasting under the direction of the State Medical Society. The weekly interviews between Dr. Robert C. Parkin, coordinator of graduate medical education at the University of Wisconsin, and a medical reporter have a growing audience in the listening range of the 39 radio stations which present this program as a public service feature. Now virtually every area of the state has this program available to it each week.

The following stations now carry "The March of Medicine":

WHBY, Appleton
†WATW, Ashland
*†WHSA, Brule
*WHKW, Chilton
*WHWG, Colfax
*WHAD, Delafield
WEAU, Eau Claire
KFIZ, Fond du Lac
WBAY, Green Bay
*†WHHI, Highland
WJMS, Ironwood, Mich.
WLIP, Kenosha
WKBH, La Crosse
WLDY, Ladysmith
*WHA, Madison
WIBA, Madison
WOMT, Manitowoc
WMAM, Marinette
WDLB, Marshfield
WIGM, Medford
WEMP, Milwaukee
WEKZ, Monroe
WNAM, Neenah
WOSH, Oshkosh
WIBU, Poynette
KAAA, Red Wing, Minn.
†WRDB, Reedsburg
WOBT, Rhinelander
*WHRM, Rib Mountain
WJMC, Rice Lake
WRCO, Richland Center
†WTCH, Shawano
WHBL, Sheboygan
WLBL, Stevens Point
WDOR, Sturgeon Bay
WDSM, Superior
WSAU, Wausau
†WBKV, West Bend
*†WHLA, West Salem

† New since 1952 report.
* On WHA chain, also carried on FM.

As in the past, all programs are recorded on tape and mailed to the stations each week. Listeners often express their appreciation for the down-to-earth terms in which these programs are presented. Typical health problems of interest to every family are presented each week. Such common topics as heart disease, cancer, weight control, prenatal care, diabetes, and infectious diseases are representative of the type of subject discussed. At the end of each program, the listener is invited to send for a free copy of the broadcast or write to Doctor Parkin regarding any matter of health pertaining to the listener or to his family.

A steady increase of "fan mail" during the past two years has been most significant. For instance, during 1951, 2,727 pieces of mail were received; in 1952, this increased to 3,639. It is anticipated that close to 1,000 more letters will be received during 1953 than were received last year. At the present time, over 500 letters a month are being received.

About three-fourths of all letters from listeners consist of requests for copies of broadcasts. The remaining one-fourth are actual inquiries concerning some problem of health. These are personally answered by Doctor Parkin; and, of course, he does not attempt to diagnose by mail. Instead, he urges

the writer to seek medical attention from his family doctor.

The Council believes that the Society should always seek an expanded listening audience for "The March of Medicine" program. County medical societies and the Woman's Auxiliary to the State Medical Society should make every effort to encourage a wider listening audience, particularly among women's groups. To this end, also, respective county medical societies in areas in which stations are located might find it feasible to promote listener interest in "The March of Medicine" program through society-sponsored advertisements in the local newspapers and spot announcements on the stations presenting "The March of Medicine."

WISCONSIN HEALTH CONFERENCE

Rural health and community organization for health improvement have long been activities of the Council on Medical Service. Your Council wishes to report that nearly 350 farm and health leaders attended a series of regional, one-day health conferences during 1952. These conferences were held in Green Bay, Madison, Eau Claire, and Wausau. The programs at each city stressed home safety, safe water and milk, immunization, and city-county health departments. However, the ability of the staff to handle arrangements for regional meetings is obviously limited; and the Council, therefore, directed that the 1953 effort in this regard be aimed at a single, state-wide health conference to be held in Madison, November 4–5, 1953. This conference will be known as the "Wisconsin Health Conference" and will be sponsored by the State Medical Society of Wisconsin and the Wisconsin Public Health Council. It is co-sponsored by 57 farm, labor, governmental and voluntary health agencies, veterans, and civic groups. The program for this Conference has already been completed, and publicity is well under way. Outstanding health leaders from the state and the nation will be among those to present discussions on the subjects of mental health, sanitation in rural schools, health insurance, cancer control, and community organization for the betterment of health through the establishment of health councils. It is hoped that the fact that the Conference will be held on Wednesday and Thursday, November 4–5, will encourage participation among physicians who normally find these days most suitable for "off-time" activities.

The Council is pleased to report that the State Medical Society of Wisconsin and the State of Wisconsin have been honored with the selection of Milwaukee as the site for the 1955 National Rural Health Conference of the American Medical Association. The Council has already met with representatives of the American Medical Association to begin planning for this Conference. In addition to making significant contributions to the program itself, the Council believes that the Society should make every effort to be a pleasant and accommodating host for the hundreds of physicians and laymen who will gather at the Conference from all over the nation.

NURSING EDUCATION

At the direction of the Council of the State Medical Society, the Council on Medical Service has begun a survey of the problems of nursing education in Wisconsin. To carry out this study, the Council on Medical Service has appointed a subcommittee with Dr. J. S. Devitt, Milwaukee, as chairman. Other members are Drs. A. S. Wishart, Eau Claire; G. S. Custer, Marshfield; J. D. Schroeder, Janesville; W. J. Tucker, Ashland; A. H. Heidner, West Bend; R. C. Parkin, Madison; G. B. Merline, DePere; and Mrs. V. S. Falk, Edgerton. Miss Adele Stahl, secretary of the State Department of Nurses, has been invited to participate in all meetings.

The committee will concern itself with the overall nurse recruitment and nursing education problem in Wisconsin. It is hoped that, through the joint efforts of physicians, nurses, hospital associations, clinic managers, nursing educators, and those in the public nursing field, some new approaches can be developed to the solution of such problems as how to establish and maintain more nursing schools for both registered and trained practical nurses, how to maintain schools at a reasonable number of locations throughout the state, and how to assure that persons so trained will remain with the profession.

This committee has only just been established and will submit reports to the Council on Medical Service and the Council of the State Medical Society within the next few months.

HEALTH INFORMATION AND EDUCATION

The Council has continued to improve and expand its activities in the field of health information and education. It feels a growing responsibilty in this field because of the necessity for improving the average person's understanding of his own responsibility for better health. Among the activities which have held the attention of the Council during the past year are the following.

Education in First Aid

The Council has prepared and distributed a colored first-aid chart, well-illustrated with caricatures, providing essential information to the lay person on the handling of common accidents and conditions of illness. These first-aid charts were initially distributed without charge to every elementary and secondary school in Wisconsin and all county and home agents of the extension division of the University of Wisconsin. They were also widely publicized among the profession. The original printing of 20,000 was soon exhausted; and in light of the great demand and the expense of production, the Council authorized that future distribution of the first-aid pamphlets be made on a cost basis. Therefore, first-aid charts are now available upon request at a cost of two cents each, in minimum quantities of 50 or more. Single copies are available without cost. The American Medical Association is reproducing this chart in a forthcoming book on good health practices. The State Board of Health is planning to distribute 10,000 copies of the first-aid chart within the next two years in its "Handbook on Health for the Elementary Teacher." Permission has been granted to other state medical societies to reproduce the chart for local use.

In connection with the first-aid problem, the Council has been interested in means of improving the transportation and care of injured persons. Therefore, it has organized a Subcommittee on Trauma to make a thorough review of information currently

available in the care of the first-aid patient through Red Cross manuals, civil defense manuals, and the like. Special study will be given to the treatment of fracture, shock, back injuries, and the loss of blood. It is believed that special educational projects may be needed to make professional people and the general public more fully aware of not only proper first-aid procedures, but when and how to move the injured person.

News Releases

During the past year, the Council is pleased to report that the State Medical Society staff has maintained and improved its news service facilities to the weekly and daily press as well as the radio stations of Wisconsin. It has been particularly active in providing news about general Society activities, the postgraduate clinics, and developments in the legislature. The Society is frequently consulted for advice and assistance in the preparation of feature articles on a wide variety of subjects. It is gratifying to know that the Society has won the confidence and the respect of many within the journalistic profession as a source of information.

"Cheers for Chubby"

During 1952, the Metropolitan Life Insurance Company carried on an extensive campaign for weight reduction in which the State Medical Society and the State Board of Health cooperated in the distribution of the film, "Cheers for Chubby." The film was produced by the insurance company and made available to the public through the commercial theaters in Wisconsin. Through these joint efforts, the film was shown in 339 theaters in Wisconsin; and an estimated 180,000 people saw the film. In newspaper and pamphlet type publicity, as well as in the introduction to the film itself, the State Medical Society and the State Board of Health were given credit for cooperating in this health education project.

Health Spot Announcements

For several months, the Society has distributed spot announcements to be used as filler material by all radio stations in Wisconsin. The Council is pleased that radio stations have found this material so acceptable. Many stations, as well as members of the listening audience, report frequent usage. The profession should indeed be grateful for the cooperation of Wisconsin radio stations in a presentation of this public service feature.

Tape Recording Loan Service

Audio-visual instruction is becoming an important device for class-room education in Wisconsin high schools today. In keeping with progress in the education field, the Council has authorized the establishment of a tape recording loan service which will permit high schools to obtain actual tape recordings of the programs presented on "The March of Medicine" to be used for instructional purposes in such courses as biology and physiology. A survey was conducted of approximately 500 high schools in Wisconsin, and it was learned that close to 80 per cent of these schools now have tape recorders. Nearly one half of these schools have indicated to the Council that they would like to utilize the Society's recordings in their classroom instruction. Accordingly, a series of 10 programs is being made available to all Wisconsin high schools this fall on a loan basis. The tapes will be provided on request only, and programs will be strictly within the control of the State Medical Society. The Council believes that this service, unique in the nation, provides an unusual opportunity for reaching the people of Wisconsin at their most impressionable age, thus establishing good health patterns as a basic habit early in life.

Television

The Council has recognized the impact of television in Wisconsin and is agreed that the State Medical Society should utilize the medium of television in health education. Some 200 films, approved by the American Medical Association or the Wisconsin State Board of Health, were recommended by the Council for showing on Wisconsin television stations wherever satisfactory arrangements could be made. All such programs are to be prepared and presented under the supervision of the State Medical Society or county medical societies. The Council believes that this is merely an initial step in the field of television and that considerably more study is necessary before it can make definite proposals for the role of television in the Society's educational and informational efforts.

INDUSTRIAL HEALTH AND OPEN PANELS

Drs. David Goldstein and D. M. Willison represent the Council on Medical Service in this activity.

Industrial Health

Minor attention has been directed to expanded activities in the field of industrial health during the past year. The "in-plant" type of teaching program has been restricted to a single conference, held in conjunction with the Medical Society of Milwaukee County. It concerned itself primarily with the field of rehabilitation, as related to industrial injuries, and proved to be highly successful. The morning session consisted of a special clinic at the Veterans Administration Rehabilitation Center, Wood, and the afternoon program was held at Allen-Bradley Co., with Frank H. Krusen, M.D., Rochester, Minnesota, as the featured guest speaker.

Growing interest and concern with employer liability, resulting from hearing loss due to industrial exposure, have prompted the Committee on Industrial Health to work with the Division on Hearing and Visual Defects of the Commission on State Departments in the development of a series of clinics under the immediate sponsorship of the Wisconsin Council of Safety. These clinics have been arranged to alert physicians and nurses to their respective responsibilities in assisting management to set up proper programs to evaluate hearing acuity of new workers and to conduct periodic screening examinations during the course of employment, to record any significant loss of hearing due to industrial noise exposure. Two such clinics have already been held and have proved to be highly successful. A third is to be held in Racine on October 14.

Open Panels

The Open Panel program continues to function effectively, with little need for adjudication of dif-

ferences between insurance carriers and physicians participating in the program. The steadily decreasing number of cases referred to the Conference Committee on Open Panels for settlement of differences reflects a growing awareness on the part of physicians to keep their charges for industrial cases well in line with other fees. Some difficulties have arisen in a few areas as to proper procedures to follow in respect to consultation, and the Conference Committee on Open Panels is preparing a statement on this and other matters which will be distributed to all insurance companies and to physicians listed on the 1954–55 panels, which will be prepared and distributed the early part of next year. It is gratifying to report that an increasing number of Wisconsin physicians are participating in the program, and that with few exceptions the employers of Wisconsin are utilizing the panels furnished through the State Medical Society of Wisconsin, thus assuring employees the privilege of choosing their own family physician for the care of industrial injuries.

RECOMMENDATIONS

1. The Physician Placement Service continue its efforts to bring physicians and communities together in satisfactory arrangements for medical service and practice and that special attention be directed toward (a) offering constructive advice for the handling of emergency cases to communities without resident medical personnel, and (b) encouraging physicians, leaving the military forces, to practice in Wisconsin.

2. County medical societies hold at least one meeting annually with representatives of the local press, radio, hospitals, and police as a means of implementing the responsibility that each has for public health.

3. The Wisconsin Press Association be commended for its interest in healthier community living, and the State Medical Society give every encouragement and assistance to a joint effort for the promotion of community health councils.

4. County medical societies and county woman's auxiliary units encourage wider listening interest in "The March of Medicine" program through newspaper publicity, pamphlet distribution, and public announcements, where feasible, through the use of county society-sponsored advertisements in newspapers and on radio.

5. The activities of the Society in the field of public relations, health education, and medical service receive the support of individual physicians and county medical societies throughout the state, and this particular report be brought to the attention of the members of every county medical society at the earliest possible meeting.

The reference committee suggested that delegates analyze this long and comprehensive report and specifically discuss it at some future date with their county medical societies.

The reference committee was of the opinion that special emphasis should be placed upon county societies cooperating in the study of nursing education and nurse recruitment and participation in the health conferences, and that each society should consider the recommendation of this Council that it meet annually with representatives of the press, radio, hospitals, and police, as a means of developing sound liaison.

The reference committee urged that each member of the Society give serious consideration to the seven recommendations made for providing medical assistance in an emergency. It further suggested that through the press the public be advised of the five recommendations outlined in the report, as providing a means of meeting a medical emergency.

On motion of Doctor Carlson, seconded by Dr. D. N. Goldstein, carried, this section of the report was accepted.

"March of Medicine" Radio Program

At this point, Doctor Carlson called upon Secretary Crownhart who stated that at the meeting of the Council of the Society preceding this meeting of the House of Delegates, a report was presented by two staff members with regard to the radio program of the Society known as the "March of Medicine." That program was authorized by the House of Delegates some years ago. The Council had asked that if opportunity could be provided, the House of Delegates be presented with a similar report.

Secretary Crownhart was granted permission of the House for this purpose and introduced Dr. Robert C. Parkin, director of the March of Medicine, and Miss Darlene Davie, full-time staff member assigned to this program, which is carried on 41 radio stations in Wisconsin and adjoining states.

Doctor Parkin stated that in 1945 the House of Delegates first took note of the fact that radio was becoming a medium of mass education, and that, as such, it could well be used by the State Medical Society of Wisconsin in a more or less official way to present to lay people accurate facts about medicine. Early in 1945 seven stations began carrying the weekly programs, sponsored by the Society, based on recordings received from the American Medical Association.

By April 1945 it was apparent that these recorded programs had no specific relationship to Wisconsin or to Wisconsin's problems. So, in that month, the Society obtained the services of the late Dr. Llewellyn Cole, who became the narrator for the "March of Medicine" series. Doctor Cole presented a 15-minute straight talk each week over 12 stations in Wisconsin.

In 1949, on Doctor Cole's death, Doctor Parkin was called to the University of Wisconsin to take over his work there and to carry on the radio programs. At that time, there were 17 stations carrying the "March of Medicine."

In September 1950 an interview type of program was started with Doctor Parkin appearing as the professional man and Mr. Myron Curry of the staff of Station WHA, Madison, as the medical reporter. This type of program was alternated with the straight talk manuscript until August 1951 when the program was converted to the interview type of program entirely.

Increased listener interest developed, and as a result, the number of stations which present the program on public service time has increased to 41.

Miss Davie stated that it is the effort of the "March of Medicine" program to present questions and comments to the lay person in language which is easily understandable. When a subject for presentation is selected, Doctor Parkin dictates facts concerning it, and further research is conducted through the files in the Society's office and through reputable magazines. A rough draft manuscript is then prepared, edited, and finally typed for use by those participating in the program. The program is recorded, and about 15 tapes are made up from the original.

An announcer's manuscript is prepared for the opening and closing of the program, as well as a cue sheet for the recording engineer of each radio station.

A complete mailing to all stations is made every week, and the tapes are returned to the Society's office after they have been used. Programs are prepared about eight weeks in advance of the time they are to be heard for the first time to allow for time lost because of illness or vacation periods.

At the end of each program, listeners are invited to send for a free copy of the broadcast script and to write to Doctor Parkin concerning any question about their health or that of their family. Such communications are addressed to the station over which the program is heard, and the mail is then forwarded to the Society's office unopened.

About three-fourths of this "fan mail" consists of requests for copies of broadcast scripts, and the remaining one-fourth are questions directed to Doctor Parkin.

Scripts are mimeographed in the Society's office and sent out, and the remaining inquiries are answered by Doctor Parkin individually. In doing so, Doctor Parkin urges the listener to seek medical attention from his family doctor.

During the winter months between 500 and 600 letters a month are received from radio listeners, and during the summer, about 200 or 300 letters are received each month.

Doctor Parkin and Miss Davie then presented a comparative type of program, to demonstrate the first type used by the Society and developments through to the present day.

COMMITTEE ON PUBLIC POLICY

J. M. Sullivan, chairman; J. K. Curtis; S. E. Gavin; J. R. Schroder; J. A. Enright; president, president-elect, and secretary, ex officio

General Introduction

The 1953 legislature is in recess and has not adjourned *sine die*, but it is unlikely that when it reconvenes this fall it will consider any matters other than those relating to fiscal and personnel problems of the state and the consideration of various gubernatorial messages.

During the course of its session beginning in mid-January, and ending in mid-June, 1,535 separate bills were introduced in both houses, in addition to a considerable number of resolutions. The volume of legislative measures, when finally bound, will provide occupancy of about 18 inches of any bookshelf. This is somewhat less than the famous Harvard Classics, and doubtless the literary content is hardly of the same caliber. However, its importance to the people of the state cannot be underestimated, and to read and fully understand these proposals requires comprehension of state affairs, administration, and problems far beyond the ken of the ordinary individual. Of the total number of measures, 145 were of public health importance in varying degree. The membership of the State Medical Society generally has been advised of the content of this legislation; and during the course of the session special bulletins were distributed to members of the House of Delegates, county secretaries, and other officials of the membership to provide them with current data.

Because distribution of information concerning actions of the 1953 legislative session was so completely carried out, this report will deviate from those of prior years and not constitute a review of legislation as it affects public health, but rather an evaluation of legislative trends and an outline of future planning of the committee.

How We Conduct Ourselves

The medical historian knows that the views of organized medicine in Wisconsin have been presented to successive sessions of the legislature as long as Wisconsin was first a territory and then a state. Of all the public health laws existing today, those of major consequence were doubtless initiated by the State Medical Society of Wisconsin.

The medical school at the University of Wisconsin came about following a period of some years of effort by organized medicine, first beginning in 1850. The State Board of Health is a similar development, as is the State Board of Medical Examiners. There is ample demonstration of the statement of the 1841 Territorial Legislature when it concluded that "well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art," and in that year created the State Medical Society of Wisconsin.

The point is that medicine in all of its many aspects is represented by the State Medical Society of Wisconsin. In a sense, it possibly can be argued that medicine has an economic interest, an interest separate from the people as a whole, an interest that is peculiarly its own and over which it exercises a certain amount of selfish control, selfish decision, and proprietary attitudes. But, physicians have a duty above and beyond treating the sick. That duty is to advise on all matters affecting the public health, and that is the concept here in Wisconsin.

How, then, should the State Medical Society present its views in the Wisconsin Legislature? Its method has been to offer facts relating to the health sciences, evaluation of those facts, and recommendations of how to translate new knowledge into improving health standards. Its purpose has been first

to explain to the public and the legislature some of the problems of public health and then to offer its best judgment as to their solution.

Many Interests

There are many "interests" which have representation before the Wisconsin Legislature. Such interests may be those of a particular segment of business or business enterprise in some particular field; others may be of organized industry or labor or of government units at municipal or county levels. In many cases, but not all of them, their legislative concept is that of advocating a particular view based upon a particular problem encountered by a particular group.

Their representatives, as are those of the State Medical Society, are frequently characterized by the somewhat odious term of "lobbyist,"—odious because it implies a type of individual who is mentally pictured as skulking about legislative lobbies and corridors, mysteriously conveying messages here and there. He is always thought of as being "up to no good," conferring in cloakroom fashion over some mysterious subject in which he, no doubt, possesses an ulterior motive, with some formidable and unworthy purpose in mind.

It is supposed that he engages in extensive entertainment of legislators for no other purpose than to impress upon them his importance, the importance of his clientele, or the fact that he is appreciative for some attitude that they have already expressed, not necessarily involving merits of a particular measure before the legislature itself.

Legislative counsel for the State Medical Society have repeatedly asserted, and they certainly are in a position to know, that while there is an occasional basis for this attitude toward the lobbyist and his activity, that element is often made to seem typical by the press and by other critics and is more historic than contemporary. Our own legislative counsel have also said that physicians, along with all other citizens of the state, can assert with justifiable pride that whatever may be the experience elsewhere, clean government is a fact, as well as a tradition, in Wisconsin. We are doubly fortunate in this state that this high standard of government is to be found equally in the legislative, along with the executive and judicial, branches.

The word "entertainment" is sometimes used indiscriminately, not only to describe what would normally fall within that term but what could just as well be included under the term "conference." The Medical Society representatives do some "entertaining" of legislators and others at mealtime because there is so little other time in which to reach these men during the legislative week which is usually limited to three or three and a half days. At these conferences legislative problems are discussed, the Society's position explained in detail, and solutions or agreements reached.

The "entertainment" which is done by representatives of the State Medical Society is and has always been minimal. It must be maintained that way, for the Society's legislative counsel and the Society's staff must be considered not as much "representatives" but rather as combining the technic of fact-finding and the skill of analysis and interpretation for the benefit of the people as a whole.

The interested citizen, and the legislator is exactly that, is fully and importantly concerned with the presentation of those facts and their accurate analysis. In the field of public health only the medical profession is qualified by training and experience to advise with government. When it does so, it must act with complete objectivity and with the interests of the entire population in view. Medicine could readily, if it failed to follow any other legislative policy, lose, confuse, or submerge its identity to the point that it could well be considered as presenting private and personal interests rather than its public responsibility.

This loss of identity is even now possible. It threatens to engulf its program and its duties, and something must be done about it.

You,—The Physician

It has been stated time and time again that for the physician to be a good physician, he must also be a good citizen. Ever-increased means of communication, the growing intricacy of domestic governmental and international relationships, the almost unlimited field of treaties and treaty negotiations and their effect upon the internal policies of independent states and nations,—these and other political activities and trends must be taken into account and constantly re-evaluated. For while the physician must be a specialist in his field, he cannot know his full responsibility without maintaining consciousness of certain civic and political responsibilities.

Public health administration and medical education will forever stand as monuments to the tremendous energy of interested physicians.

Their value in terms of increased life, comfort, and productivity of all segments of our population is literally incalculable. Equally significant, and too often overlooked, is the field of medical research upon which the practicing segment of the profession constantly depends. It must always be borne in mind that the physician in public health administration, the physician teacher in the medical schools of the country, and the physician researcher are all as truly members of the House of Medicine as the private practitioner, and that their professional interests are, and must remain, identical with those of the private practitioner. Each of these components of medicine has played an active and vital part in legislation which is part of the bulwark of public health.

All elements of medicine are keenly aware of their responsibility in seeing that medicine is taught, practiced, and interpreted in the best American tradition. The maintenance of this tradition serves

as a continuing foundation or framework for constantly improved legislation in the field of public health.

Quackery and Cultism

An increasingly disturbing development of recent years deserves to be noted and commented upon. That development can perhaps best be described as one of confusion between the non-genuine and the genuine. It is the situation in which the cultist and the quack are considered by some segments of our society to be entitled to the same privileges and standing as physicians, even though their training and standards are not equal. For these developments the medical profession must bear some share of the full responsibility.

As medicine has become increasingly scientific, as its skills have become increasingly known, and as the demands upon the medical practitioners have grown, we have become an increasingly busy profession, under pressure of great and personal immediate needs, drawing away more and more from the position of the family counselor to that of a hurried and harassed profession, leaving it to the individual practitioner to learn how best to serve the complications that attend ill health, sudden accident, a catastrophe within the family, the sadness of mutilation, lingering illness, and final death. People expect more from us than some of us have been inclined to give, and what they expect is no less than we should give. In their demands, in their needs for compassion, for the advice that can come from those who have seen the situation on other occasions, and who know how best solutions may be brought about, they are gradually developing a tendency to turn to untrained individuals who will take the time to advise, although their qualifications may be poor and even unacceptable by the standards of modern medicine.

Cultism and quackery thrive among the credulous and the neglected. We have in this state a substantial number who are not physicians, who possess no medical training, who adhere to an exclusive dogma in whatever they provide the sick, and who by any standard of excellence fail to be either trained or competent. Some of these exist in the state by reason of a licensing statute, and others have simply been tolerated as they have endeavored to engage some foothold in such a field as that of naturopathy, a form of quackery of the first water.

The Committee on Public Policy proposes now, and for the future, a most careful, honest, and detailed survey of what is coming about and why it is coming about and what should be done about it. It proposes to locate every chiropractor in the State of Wisconsin, and to ascertain whether his education progressed at any point beyond high school level into the level of recognized college training. It will evaluate training afforded him under the title of a chiropractic course. It will ascertain his practices, the extent to which he possesses skills of training, and the extent to which his success depends more on his personality and his ability to capitalize by serving areas not adequately served by the trained individual.

The purpose of this survey will not be to discredit or to persecute any group. Rather its purpose will be to inform the public of the facts and, if needed, to recommend that the limits of the practice of such cultists be measured by their training and competence, rather than by their pretentions. Licensure is a privilege, not a right, and it should be measured by demonstrable competence rather than by claims of competence.

The survey will not stop with the group named above but must be extended wherever it is felt to be necessary. For example, it is openly admitted that there are approximately 120 naturopaths located, and presumably practicing, in Wisconsin today.

Naturopaths practicing in this state do so in violation of the law. The real story of naturopathy needs to become better known, needs to be understood by every citizen of the state, so that those who are under the mysticism of salesmanship may not be misled or may not mislead others.

Conclusion

For many years the greater part of the burden of education of the public and of initiating sound legislation in the public health field has been carried by the medical profession. It is believed reasonable to expect increased support from the related and ancillary professions and others which are associated with medicine in public health.

There is every reason to believe that each of these professions or groups has come to be aware of its share of the total responsibility for protecting and improving public health standards.

Your committee notes with pleasure that the 1953 legislature modernized the Medical Practice Act and is confident that this will enable the State Board of Medical Examiners to perform its important functions much more effectively than in the past.

This report has been prepared on three beliefs, all of which have been amply supported by the experience of the State Medical Society.

The first is that the medical profession must never abdicate its position of responsibility for public health education which it shares with public health administrators and with medical educators. It is this continuous process of objective education of an entire population which alone can provide the climate for progressive public health legislation. If the public is not prepared to accept or to desire improved health standards, its legislators will be correspondingly apathetic or even hostile.

Second, the medical profession must continue to furnish primary leadership in public health legislation, even though again it properly shares this field with public health administrators and with educators.

Third, the Society must never compromise any matter of principle which is involved in such health legislation. What it cannot do by persuasion in one session, may have to be postponed to a later time, but the profession must never permit the compromise of health standards as the price of success of its programs. Were it ever to do so, it would be guilty of a grave disservice to the entire population.

Its program and thinking must, of necessity, be flexible as to methods and details, but once a position has been taken or a recommendation offered which involves a principle of health standards, the Society must be prepared to see its proposal defeated before it will permit its dilution or sacrifice.

The reference committee recommended acceptance of the report of the Committee on Public Policy, and on motion of Doctor Carlson, seconded by Dr. T. W. Tormey, Jr., Madison, carried, it was accepted.

THE COMMISSION ON STATE DEPARTMENTS

This report was included as a part of the Council report which appears under business of the first session of the House of Delegates.

The reference committee recommended adoption of the entire report, and specifically emphasized that, in taking such action, this House of Delegates should recognize the activities of the Division on Maternal and Child Welfare and its proposal to conduct studies in the field of fetal and neonatal deaths during 1954. It was understood that the Division proposed to publish results of its studies for teaching purposes at an appropriate time.

Other contents of the Commission's report which the reference committee felt deserved emphasis included the study of Wisconsin commitment laws and the work being done by the Division on Public Assistance in an over-all study of the relationship of physicians to county institutions.

At this point, the reference committee also stated that while the remarks of the state health officer are not referred to a reference committee, as they do not come within the committee structure of the Society, the committee was of the opinion that Doctor Neupert merited commendation by the medical profession of this state. He has always been most cooperative in reviewing for the House of Delegates progress within his own department, as well as problems confronting it, and has unselfishly devoted his services to the interest of good public health.

The reference committee, therefore, recommended that the Commission on State Departments review the remarks of the state health officer and assist him in whatever way it can. The State Health Department especially needs the cooperation and help of the profession in alleviating the serious problems that now confront it.

Each section of the Commission's comprehensive report deserved special emphasis, but the reference committee found nothing controversial in the proposals outlined. It therefore recommended adoption of the report, with endorsement of all recommendations.

On motion of Doctor Carlson, seconded by Dr. T. A. Leonard, Madison, carried, this section of the report was accepted.

COMMITTEE ON BLOOD BANKS

The reference committee directed particular attention to a national study being made through the American Medical Association as to the relationship of the entire blood bank program with the American Red Cross. The Blood Bank Committee advised that it will adhere to the basic policies of the A.M.A. and serve as a liaison between blood banks operating in Wisconsin and regional offices of the American Red Cross. The reference committee recommended that the entire report be endorsed.

On motion of Doctor Carlson, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

COUNCIL ON SCIENTIFIC WORK

T. O. Nuzum, chairman; J. W. Gale; S. A. Morton; P. A. Midelfart; Maurice G. Rice (Ex-officio members: R. S. Baldwin; J. S. Hirschboeck; W. S. Middleton)

The primary function of the Council on Scientific Work is that of planning postgraduate education —scientific programs of the Annual Meeting and also various types of programs offered on a local or regional basis.

With the continued growth of voluntary health agencies in various fields of medicine there has been continued need to coordinate teaching programs and to avoid duplication and overlapping. As a means of achieving this end, the Council on Scientific Work has initiated the formation and functioning of the Coordinating Committee on Postgraduate Education, which has pooled the teaching efforts of the two medical schools, the State Board of Health, the Wisconsin Academy of General Practice, and the voluntary agencies: namely, the Wisconsin Anti-Tuberculosis Association, Wisconsin Heart Association, and the Wisconsin Division of the American Cancer Society. It is anticipated that other groups, such as the Wisconsin Arthritis and Rheumatism Association, will also develop their professional education programs in cooperation with the existing membership of the Coordinating Committee on Postgraduate Education.

To summarize, these two basic functions of the Council on Scientific Work are of immediate concern to members of the House of Delegates.

The Annual Meeting

Under the direction of J. W. Gale, M. D., the current Annual Meeting program provides an organization of material which the Council has felt is of most direct value to the membership of the State Medical Society. Efforts have been made to correlate the program with official meetings of some state specialty groups. This has been achieved in cooperation with the Wisconsin Society of Anesthesiology, the Wisconsin Society of Obstetrics and Gynecology, the Wisconsin Orthopedic Society, the Wisconsin Society of Pathologists, and the Section on Ophthalmology and Otolaryngology. By developing special parts of the program in the specialty fields indicated, the Council has been able to serve these special societies by bringing outstanding teachers as program participants, and at the same time it offers the general membership an opportunity of attending meetings of a specialized character if the subject material and lecturers have appeal. A review of the program will indicate the efforts taken to provide a scientific program which is practical and still reflective of new procedures and technics of therapy. More than 20 outstanding men have been secured as teachers, coming from such distant points as the East coast, New Orleans, and other medical teaching centers. The Council feels justifiable pride in presenting such an outstanding scientific program,

and it is hoped that the delegates will take part in as many of the scientific sessions as their time will permit.

Trying to keep the program as direct and practical as possible, the Council has again provided a number of teaching programs in the early morning which will provide ample opportunity for audience participation and the asking of questions. Anatomic dissections, gross tissue displays and discussion, manikin demonstrations, explanation of methods employed in the occupational and physical therapy of cerebral palsy patients, and a repeat demonstration on fractures, all provide avenues for direct, individualized teaching which should make the Annual Meeting one of direct benefit to those members who attend and participate.

Postgraduate Teaching Courses

Seventeen individual programs, organized in monthly circuits from January through June, have provided the membership of the State Medical Society of Wisconsin with unusual opportunities for practical teaching without undue absence from their practice. These one-day clinics have proved to be increasingly successful and have been presented as a coordinated effort of the agencies listed above. A summary of the clinics shows that nearly 600 members took part in the 1953 meetings, with many attending two to five separate monthly conferences. The cost has purposely been kept low, but even so, the over-all cost, borne out of the dues account of the State Medical Society, has been less than 50 cents per member (not counting time of the assistant secretary and one member of the secretarial staff, both of whom spend about one-quarter time on this type of work). The low net cost to the membership of the State Society has been due to the financial support of the cooperating agencies, with the State Board of Health contributing $3,100 for speaking talent, and $500 donations from the Wisconsin Heart Association and the Wisconsin Division of the American Cancer Society.

A survey conducted among all those who attended the 1953 clinics indicates great interest in these teaching programs, and repeated expressions of satisfaction as to services rendered by the State Medical Society of Wisconsin to its members. It provides one avenue through which the State Society can demonstrate direct services to its members, and it is most gratifying to note the appreciation of members for the programs presented.

On the basis of participant reactions the Coordinating Committee has made plans for substantially the same type of programs in 1954, though meetings on a circuit basis in January and February will be avoided because of weather conditions. In addition to the basic circuit teaching programs, the Coordinating Committee approved three special programs on hearing loss and its relationship to compensation (two such meetings have already been held, and a third is to be held in Racine on October 14), three special cancer clinics described in the report of the Committee on Cancer, three meetings on mental deficiencies of children and special problems of our state colonies, and a series of one-day conferences on "Diseases of the Chest," supported cooperatively by the Wisconsin Anti-Tuberculosis Association, the Wisconsin Heart Association, and the Wisconsin Division of the American Cancer Society.

The Council on Scientific Work looks back to the past year with considerable satisfaction, and it is pleased to report its work to the House of Delegates. While new demands are being made upon the physician through the expansion of health insurance, governmental health services, and other socioeconomic programs directly affecting his practice, he still is essentially a scientifically trained individual dedicating his life, his talents, and his knowledge to the care of sick people. This places on his shoulders a direct responsibility to acquire knowledge, wherever it can be found, and to translate it into his care of patients. To this end the Council on Scientific Work has made a distinct contribution this past year, and all those who have shared in the endeavors have a sense of service to the members of the State Medical Society. It is a pleasure to present this report to the House of Delegates, and the Council stands ready to carry out any suggestions of the House and the individual delegates as to ways in which the postgraduate education program of the State Medical Society can be improved.

Recommendation

Delegates assist the Council and the Coordinating Committee on Postgraduate Education in making all future teaching programs even more successful by urging all members of their individual county societies and members of their hospital staffs to participate in the various programs offered.

The reference committee emphasized that the primary purpose of medical organization is the advancement of scientific knowledge. The work done by the members of this Council during the year, and particularly in preparation for this meeting, is a demonstration of outstanding service.

With the growth of voluntary health agencies it is important to point out the continued need for coordination of teaching programs so as to avoid duplication and overlapping. This can be accomplished through the Coordinating Committee on Postgraduate Education.

Through the efforts of this Council, members of the Society have been given splendid opportunities to keep abreast of scientific developments, and the reference committee recommended that the Council's report be accepted with high appreciation by this House of Delegates.

On motion of Doctor Carlson, seconded by Dr. D. N. Goldstein, Kenosha, carried, this portion of the report was accepted.

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, the report of the Reference Committee on Reports of Standing Committees, as a whole, was adopted.

THIRD SESSION

Wednesday, October 7, 1953

The third session of the House of Delegates convened at 9:00 a.m., Dr. G. E. Forkin, Speaker, presiding.

Report of the Committee on Credentials

The Committee on Credentials verified the registration of 52 delegates and nine alternate delegates entitled to vote at this session of the House of Delegates.

On motion of Dr. T. J. Aylward, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 61 was accepted as the official roll of this session of the House, to stand for the entire session.

Report of Committee on Nominations

Dr. J. A. Enright, Milwaukee, chairman of the Committee on Nominations, presented the following resolution for consideration by the House:

WHEREAS, the membership of the House of Delegates is fully appreciative of the necessity for holding three meetings during an annual session of the State Medical Society, and there is also appreciation on the part of the membership of the importance of allowing the several reference committees time for unhurried consideration of the matters which are assigned to them, and

WHEREAS, the members of the House are at the same time desirous of having fuller opportunity to attend the scientific meetings and exhibits that are professionally so important a part of the Annual Meeting; be it, therefore,

RESOLVED, That the Council be invited to survey the possibilities of holding part or all of the sessions of the House, and part or all of the deliberations of the reference committees, in advance of the dates of the scientific sessions, and in the course of such survey that the Council weigh carefully the desirability of permitting participation of the general membership in the open sessions of the several reference committees, and also the desirability of holding one or more of the sessions of the House at a time when the general membership is able to attend them; and be it further

RESOLVED, That the Council publicize the results of its study in the *Wisconsin Medical Journal* as far in advance of the effective date of such change as possible, should it conclude to make changes in the traditional times of holding sessions of the House; and be it finally

RESOLVED, That any changes in meetings of the House and of its reference committees which the Council deems feasible be put in effect at the earliest practical date.

It was moved by Doctor Enright, seconded by Dr. E. C. Cary, Reedsville, that the resolution be adopted. Following discussion the motion was carried unanimously.

The names of the following nominees were presented for official positions in the State Medical Society:

For President-Elect: Dr. A. J. McCarey, Green Bay

For Speaker of the House: Dr. L. O. Simenstad, Osceola

For Vice-Speaker of the House: Dr. J. W. Fons, Milwaukee

For Delegate to the A.M.A.: Dr. W. D. Stovall, Madison

For Alternate Delegate to the A.M.A.: Dr. G. E. Forkin, Menasha

Milwaukee was the choice for the next Annual Meeting of the Society.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. T. C. Hemmingsen, Racine, carried, Doctor McCarey was unanimously elected to the office of president-elect.

On motion of Dr. Robert Krohn, Black River Falls, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, Doctor Simenstad was unanimously elected Speaker of the House.

On motion of Dr. Robert Krohn, Black River Falls, severally seconded, carried, Doctor Fons was unanimously re-elected Vice-Speaker of the House.

On motion of Dr. A. A. Quisling, Madison, severally seconded, carried, Doctor Stovall was unanimously re-elected delegate to the A.M.A.

On motion of Dr. N. A. Hill, Madison, seconded by Dr. E. C. Cary, Reedsville, carried, Doctor Forkin was unanimously elected alternate delegate to the A.M.A. (Doctor Fons presided for this election.)

On motion of Dr. G. W. Carlson, Appleton, severally seconded, carried, Milwaukee was selected as the place for the 1954 meeting.

Speaker Forkin appointed a special committee, composed of Dr. H. J. Kief, Fond du Lac; Dr. J. W. Prentice, Ashland; and Dr. John Enright, Milwaukee, to escort the president-elect to the platform.

Election of Councilors

The House then proceeded to the election of councilors with the following results:

In the Seventh District, on motion of Dr. J. J. Satory, La Crosse, seconded by Dr. T. W. Tormey, Jr., Madison, carried, Dr. J. C. Fox, La Crosse, was unanimously re-elected.

In the Eighth District, on motion of Dr. C. E. Koepp, Marinette, seconded by Dr. T. W. Tormey, Jr., Madison, carried, Dr. J. M. Bell, Marinette, was unanimously re-elected.

In the Ninth District, Dr. E. P. Ludwig, Wausau, presented the name of Dr. R. E. Garrison, Wisconsin Rapids, for nomination as councilor. Speaker Forkin stated that the present councilor, Dr. E. E. Kidder of Stevens Point, had had a serious illness, and there had been question as to whether the delegates from that district should remain without adequate representation or elect a new councilor. On motion of Dr. H. E. Kasten, Beloit, seconded by Dr. Robert Krohn, Black River Falls, carried, Doctor Garrison was unanimously elected councilor. (See "Appreciation Expressed to Doctor Kidder," next page)

In the Tenth District, on motion of Dr. L. O. Simenstad, Osceola, severally seconded, Dr. R. G. Arveson, Frederic, was unanimously re-elected.

In the Thirteenth District, on motion of Dr. J. D. Leahy, Park Falls, seconded by Dr. Robert Krohn, Black River Falls, Dr. C. E. Zellmer, Antigo, was unanimously re-elected.

Acceptance of the President-Elect

Dr. A. J. McCarey was escorted to the platform by the special committee which had been appointed by the Speaker. In his speech of acceptance, Doctor McCarey made the following remarks:

"I wish I had the wisdom of Solomon and the eloquence of Demosthenes, but I am standing before you as one of your colleagues who, by a touch of the magician's wand, perhaps, has been raised from the ranks to this position of responsibility and leadership.

"I have been in the House of Delegates and on the Council for many years, and I have learned a great many things about this Society of ours. I am very, very proud of its accomplishments, as are we all. When we realize that it has been in existence for over a century and has never failed to meet every test, that it has solved all its problems wisely, that it has settled all its differences amicably, there is every reason to believe that its success in the past will continue in the future.

"What I am thinking about this morning particularly is its spirit. I have discerned a spirit in this organization which is more than ordinary. Enthusiasm? More than that. It is a spirit of devotion. It brightens the eyes of our officers, and when they speak to us it rings in their voices. This House of Delegates is filled with it.

"At the meetings of our committees, our councils, our commissions, it is in generous measure. Our past-presidents come wandering back to our Annual Meetings just to bask in the warmth of it; and over on East Gorham Street, on the shores of Lake Mendota, a great executive secretary, affectionately known as "Charlie," and his loyal staff, are working for us and for the people of Wisconsin with a devotion that is magnificent. To be elected president-elect of an organization like that is a great honor, for which I thank you very much.

"Another year shall pass, and you and I in another autumn shall meet, and then my term of office will begin. During my year of preparation and during my term of office I will try as best I can to personify that spirit of devotion to your Society and to mine."

Appreciation Expressed to Doctor Kidder

Dr. K. H. Doege, Marshfield, referred back to the election of a new councilor in the Ninth District to replace Dr. E. E. Kidder of Stevens Point, who had been ill. Doctor Doege stated that Doctor Kidder had rendered very efficient and timely service, attending practically all sessions of the Council. He asked that the House of Delegates go on record as being particularly appreciative of his services, and that in relieving him of his duties, the House have in mind that he is relieved of the necessity of attending so many meetings. He stated that Doctor Kidder is the honor-bound type of man who would do everything possible for the Society.

A unanimous rising vote was recorded in appreciation of the services rendered by Doctor Kidder.

Speaker and Vice-Speaker Presented

Doctor Forkin presented Dr. L. O. Simenstad of Osceola, new Speaker of the House, who stated his opinion that the Speaker of the House should be the liaison between the delegates and the Council, the president, or some of the officers. He urged the members to act through their Speaker so that a closer relationship could be established between the delegates and the Speaker and the Council.

Dr. J. W. Fons, Milwaukee, thanked the House for the confidence expressed by the members in reelecting him to the position of Vice-Speaker and stated that the new Speaker and all officers, delegates, and councilors of the Society would receive his full cooperation.

The Bricker Resolution

Dr. R. G. Arveson, Frederic, chairman of the Council, asked the privilege of the floor to present a report from the Council on the Bricker resolution. Included in his report were the following remarks:

"The Council met this morning to consider the request you made yesterday regarding the Bricker amendment. I do not think the matter was discussed before the House as fully as it might have been, and in the same breath I want to say that I admire the stand of Doctor Beffel of Milwaukee when he presented his arguments against it and moved to table it.

"As American citizens, interested in what is now one of the great debates in our country's history, we, as educated men—as physicians—ought to fully understand what it is all about as far as the information we can get is concerned. Therefore, to that end I wish to make this statement:

"At the first session of the House of Delegates on October 5, 1953, a supplementary report of the Council recommended to this House of Delegates that it should follow and support action taken on two occasions by the House of Delegates of the American Medical Association in support of the Bricker resolution, proposing a Constitutional amendment placing some limits on the treaty powers of government officials. This action by the Council was by unanimous vote, taken after careful consideration of the subject, and consistent with the action of the House of Delegates of the A.M.A.

"At its second session the House of Delegates of the State Medical Society referred the subject back to the Council with the recommendation that the whole matter be tabled. The Council met in special session this morning. It cannot in good conscience as a Council, and its members cannot in good conscience as American citizens, do other than bring this subject before the House of Delegates so that each member of the House may be fully cognizant of the circumstances which have led to its support by the American Medical Association.

"At this point, Mr. Speaker, by formal action of the Council, Mr. Murphy, attorney for the State Medical Society, and Mr. Joseph Stetler, secretary of the Legislative Committee of the American Medical Association, will discuss the subject so that the House may be benefited by hearing the same background and explanation which the Council had before it acted favorably in the matter on October 4.

"Following their discussion I shall present the recommendation of the Council that this House of Delegates, by a roll call vote, formally vote upon this important issue."

EXCERPTS FROM PRESENTATION BY MR. ROBERT B. MURPHY

"I am going to speak to you for a few minutes as citizens and give you some basic orientation in a subject so much misunderstood and so often ill-presented. I am going to try to point out to you your responsibility for knowing at least the gross fundamentals of the field as citizens.

"Mr. Stetler, who has a specialized backround in the legislative work of the A.M.A., and who spends roughly half of his time in Washington and the other half in Chicago with the A.M.A., will follow through and will give you more specialized presentation of the problem of constitutional law and international law presented by this proposed amendment as it would affect public health and the profession of physicians.

"When our Constitution was drafted, the following provisions were made with reference to laws: That the Congress of the United States should make laws pursuant to the Constitution. The same Founding Fathers said, as to treaties, that the President and the Senate should make treaties under the authority of the United States without any reference to the Constitution.

"As long as the subject matter of treaties stayed within their established boundaries, which used to be matters of peace and war, the rights of the citizens of one state in another country, questions of boundaries—yes, of international navigation, of commerce as expressed through reciprocal trade treaties and through tariffs and the like—as long as those were the subject matters of treaties, it was not a very pressing matter.

"But during the past 30 years or so, the effort has been made increasingly to legislate local domestic policy through the device of treaties; and under the power that is vested in the Congress and in the President acting alone, it is not only possible but it has happened on a number of occasions that the laws of states have been set aside by a treaty which was not even made in this country but which was signed abroad.

"I can give you no better authority for the accuracy of this rather remarkable development than the words of John Foster Dulles, one of the world's most distinguished citizens, who, in an address to the American Bar Association regional meeting at Louisville, Kentucky, in April of last year, at a time when he was a private citizen, said: 'The treaty-making power is an extraordinary power, liable to abuse. Treaties make international law, and also they make domestic law. Under our Constitution, treaties become the supreme law of the land. They are, indeed, more supreme than ordinary laws for congressional laws are invalid if they do not conform to the Constitution, whereas treaty law can override the Constitution. Treaties, for example, can take powers away from the Congress and give them to the President; they can take powers from the states and give them to the federal government or to some international body, and they can cut across the rights given to the people by their constitutional Bill of Rights'—which includes the right of trial by jury, free speech, freedom of worship, assembly, and the like.

"To meet that situation, the American Bar Association, through a special committee that worked on the matter for seven years, had introduced through Senator Bricker of Ohio a resolution last year, which had the signatures of 57 other senators, a majority of the Democratic senators and a majority of the Republican senators combined.

"No final action was taken on that resolution last year. It was re-introduced into the new Congress this last January, and significantly has the number '1,' Senate Resolution No. 1. It bears 64 names; it bears all but four of the Republican and almost half of the Democratic senators' names.

"In that sense, and in a very accurate sense, it is not a political issue. It cuts across party lines.

"What is politics, gentlemen? It is public business—collective public business. Health has been in politics in the sense that it has been of interest to man collectively as well as individually since the dawn of time.

"Health must always be presented with the greatest truthfulness and objectivity possible, but it is a part of politics legitimately.

"No one has disenfranchised you unless you care to disenfranchise yourselves. You begin and end life as citizens. You happen to be physicians.

"Continuing, let me say that there has been an increasing fear on the part of those who know the subject and who work with it that if this lack of limitation on a treaty-making power continues, it will be perfectly possible to achieve by the back-door method of secretly-arrived-at agreements, not even disclosed to our own Congress in many instances, not alone socialization (because that is a grossly misused term), not communization alone, but more accurately the destruction of the very fundamentals of our composite values—those things that are known as the American way or the American system.

"Section 1 of the Bricker resolution, which would amend the Constitution, provides: 'A provision of a treaty which conflicts with this Constitution shall not be of any force or effect.' It is proposed that the Bricker resolution make possible amendments to the Constitution.

"Section 2 reads: 'A treaty shall become effective as internal law in the United States only through legislation which would be valid in the absence of treaty.' Here, 'internal law' means, for example, the law of Wisconsin—the law of Milwaukee (in so far as its ordinances are concerned)—the law of Milwaukee County as far as the county is concerned.

"Section 3: 'Congress shall have power to regulate all executive and other agreements with any foreign power or international organization. All such agreements shall be subject to the limitations imposed on treaties by this article.'

"It has two other sections, but they have to do with the mechanical implementation of it, and how many states must pass it.

"What would these three sections do? What are they designed to do?

"The first section is designed to make impossible any longer the adoption of a treaty which contains provisions in conflict with the Constitution.

"What about Section 2? It is intended that the President cannot sign on behalf of a whole people an agreement which sets aside the law of Wisconsin or an ordinance of the City of Milwaukee without consulting anyone from those places, without any opportunity for them to be heard or to talk back or to have any recourse whatsoever.

"Our Supreme Court has said, first, that it is doubtful if there are any limits to the treaty-making power; second, there is no such thing, by virtue of the first statement, as an unconstitutional treaty. Finally, we have never set aside a treaty.

"Another witness before Senator Wiley's committee said that at a time when it was conceded there was overcentralization of federal powers at the national level, it was a little difficult to understand demands that there be no limits placed on the international bargaining powers of the same government. The reason is that modern communications, modern science, have all but annihilated international boundaries. Hence, Section 3.

"There is authority given today, by virtue of previous treaties, for the imposition of United Nations law upon you and me in Wisconsin this morning. It has existed for eight years. The World Health organization has the same kind of authority. The International Labor Organization has the same authority. The International Court of Justice binds the United States—and it binds it to a point where it has announced in some of its decisions that what it said was the law, no matter what the United States Supreme Court has said. These are situations in which the United States is thus subjected to foreign law by noncitizens, which gets at some of our most fundamental rights.

"That, in brief, gentlemen, is the problem and the issue before you as citizens. What is even more important than the issue before you, as physicians, is whether you feel a concern over the ever-present possibility in some field, and facts in others, that legislation affecting all phases of your practice and of public collective business may be achieved in disregard of our constitutional processes, in the undisclosed and untrammeled discretion of an executive and his advisors.

"The American Bar Association contains the only body of men in this country trained in constitutional law and in international law. Its House of Delegates, meeting in February one year ago (in a House of Delegates modeled after the American Medical Association's machinery since 1936), acted favorably on the first Bricker resolution. At San Francisco at its annual meeting last year it reaffirmed that position. It was under very heavy pressures in its House of Delegates in Boston six weeks ago. After five days of consideration and a final three-hour debate, the House of Delegates reaffirmed its support of the Bricker amendment by 177 to 35.

"That is the American Bar's answer to this problem. It does not consider that it has compromised any of its principles in expressing its position in this matter, which is as fundamental and more immediate in its results and in its implications than many of the things that you hold rather significant in daily practice.

"There lies implicit in the present machinery, if it is permitted to run without limitations, the possibility of the imposition of patterns on your practice, of the imposition of strange health standards, and of the remaking of the educational standards which you have made the marvel of the world in the past 50 years."

EXCERPTS FROM PRESENTATION BY MR. JOSEPH STETLER

"I am here today to talk to you at the specific request and invitation of the Council. I have no desire to force upon you my personal views on the Bricker resolution nor, as a matter of fact, to try to sell you on the position of the American Medical Association. Obviously, I have had some close connection with this legislative matter for some time, and I can assure you that I am happy to share with you any knowledge or information I may have. I think I can give you sufficient detail so that you can appreciate how this matter affects you as individual physicians and as members of the medical profession.

"The first example is a series of friendship treaties that were before the Congress and the Senate this past year. These were treaties with Denmark, Holland, Israel, and Greece, which provided for a variety of things. They dealt with immigration quotas, with citizenship requirements, and they also dealt with matters of licensure in the various states.

"If these treaties had been ratified as originally prepared, many of the requirements of the various states in the licensing of physicians would have been abrogated. Personally, I believe (and I think you believe, too) that the states certainly have the right to decide what qualifications shall be applied to members of the various professions practicing within that state.

"The second thing I would like to mention briefly is the United Nations Charter, which was ratified in 1945. There are two rather general sections of this Charter which I am going to refer to, which lay the framework for some rather broad congressional powers in the field of health, among other things.

"Article 55 provides in part: 'The United Nations shall promote solutions of international, economic, social, health, and related problems.'

"Article 56 provides that 'all members of the United Nations pledge themselves to take joint and separate action in cooperation with the organization for the achievement of the purposes set forth in Article 55.'

"Thirdly, I would like to mention the International Labor Organization. This is a subsidiary organization of the United Nations, formed in 1917. The United States has been a member of the International Labor Organization since about 1937. There are at the present time 65 participating nations, all of whom have three delegates to the meetings of the ILO.

"Originally their interests were confined pretty much to international labor problems; and although the medical profession for some time has been aware of the potential danger of the International Labor Organization, I believe it was not until June of

1952 that we fully realized just what might come to us through the operations of that group.

"In 1952 in Geneva the International Labor Organization adopted a convention—and I might say that a convention of an organization like the International Labor Organization is tantamount to a treaty—which was labeled, 'Minimum Standards of Social Security.' That convention provided, among other things, for a suggestion of permanent and total disability under our present social security system—cash sickness benefits, maternity care, and a variety of health provisions, which, incidentally, have been turned down by our Congress, which in total would amount to socialized medicine, if you will.

"We feel (and I presume you also feel) that when the members of the Congress, the House and the Senate, have turned down socialized medicine (and they have turned it down because their constituents at home have indicated that they do not want socialized medicine), we feel it is entirely improper for such a provision to be foisted on the American public through a vehicle such as a treaty.

"It is significant to note that as far as our delegates to the International Labor Organization are concerned, they are composed of a government representative, a labor representative, and a management representative. Under the past administration we have rather suffered through the choice of our government representative. I think 22 of the last major issues that were decided at the ILO saw the government representative siding and voting with labor. Obviously, the management representative had very little chance.

"Certainly we are not about to accept the Minimum Standards of Social Security, as proposed in June of 1952 by the International Labor Organization. There are a variety of bills now pending in Congress, before the House, and some before the Senate, which would provide for permanent and total disability insurance, some for cash sickness benefits and a variety of health measures which we are very willing to have come through the proper sources, before congressional committees, where we have an opportunity as professional people and as individuals who testify and let Congress know how we feel about these bills, to give our public and our constituents an opportunity to let Congress know how they feel.

"If, after these processes are applied, Congress decides in its discretion that we should have permanent and total disability insurance, then we will have it, and we will cooperate in the implementation of that legislation; but we do not want it without the application of what we consider democratic principles.

"If such a convention as the Minimum Standards of Social Security, were ratified by two-thirds of the Senate present, it would become the supreme law of the land. Frankly, we feel that that poses a rather dangerous threat. We feel that it is of sufficient significance to warrant the active interest of the medical profession in insuring that it cannot be accomplished.

"The vehicle for insuring that it cannot be accomplished, which is available to us at the present time, we feel, is the Bricker amendment. That, briefly, is why the American Medical Association has twice voted through its House of Delegates to approve the principle of the Bricker amendment.

"In the past there was a slight difference between the original amendment proposed by Senator Bricker and the position taken by the American Bar Association. The resolution, as reported favorably by the Senate Judiciary Committee in the first session of the 83rd Congress, resolves those differences. So, the co-sponsors of the Bricker resolution and the American Bar Association are in agreement on the present resolution before the Senate. We therefore are also in accord with that present resolution.

"In all other major countries except the United States a treaty, to become the law of the land and to take full force and effect, must have implementing legislation. That is not so in our country. As Mr. Murphy indicated, that is one of the effects of the Bricker resolution. It would require that if a treaty or a convention affected domestic issues, it would have to be implemented by separate legislation of the House of Representatives and the Senate before it would become the law of the land.

"We feel that is proper. We are going to fight for it very strenuously in the next session of Congress. We realize it is a controversial issue and that there are strong forces on either side; but we feel that there is a very good chance that this resolution will be adopted during the next session of Congress."

RECOMMENDATION OF THE COUNCIL

Doctor Arveson stated in conclusion that the Council, acting as a reference committee for the House, recommended that the House, by roll call vote, support the position of its parent organization, the American Medical Association, and record its approval of the principle expressed in the Bricker resolution.

Dr. S. W. Hollenbeck, Milwaukee, requested a recess for a delegates' caucus before a vote should be taken, and Speaker Forkin declared a recess.

At the conclusion of the recess, Dr. K. H. Doege, Marshfield, inquired whether Mr. Murphy would present some of the arguments used by the opposition to the Bricker amendment. Speaker Forkin called upon Mr. Murphy to do so.

OPPOSITION'S ARGUMENTS

Excerpts of Mr. Murphy's statements as to the opposition's arguments follow:

"The first major argument is found in the quotable portion of President Eisenhower's press conference in July 1953.

"He said in substance: 'I want to be unfettered in my negotiation with foreign powers.' It is a little difficult to explain omniscience in any man in one field of public law when it is conceded that he does not have it in the others.

"The second one usually offered is that many fields of international agreement, many points of impact of international business, would be slowed down or even made impossible, such as the extradition of criminals, the effort to control the world menace of the opium traffic at the illegitimate level.

"The answer made to that is that the extradition of criminals was handled without treaties until

virtually 1890, and then remained under general statute and was made a matter of treaty only in specific instances when certain countries offered certain powers.

"There are now both treaties and statutes on extradition, but for a long time there were no treaties, and criminals were extradited under the statutes.

"As for the international narcotics traffic, that has been under a statute for a long, long time—since the Pure Food and Drug Act of 1906 or 1907—as modified by the Poppy Act, as it is popularly named, in 1942. Those are statutes, gentlemen, not treaties.

"It may be that it could be either a statute or a treaty, but the fact remains that the traffic controls have been set up by statute, and that right of statute continues.

"One of the things that the Bricker amendment seeks to do is to prevent the setting aside of statutes by treaties. Those are not exclusively matters for treaties, and they have not been operated under treaties, but under statutes.

"Those are the two principal arguments made. There are a number of other arguments, but they are subsidiary and fall under them."

QUESTION AND ANSWER PERIOD

Dr. D. H. Witte, Milwaukee, one of the delegates of the State Medical Society to the American Medical Association House of Delegates, requested permission to ask Mr. Murphy a question, the answer to which to a large extent was responsible for his own action in the A.M.A. House. Permission was granted by Speaker Forkin.

Doctor Witte then inquired whether it was not a fact that as things are today, without the Bricker amendment, it would be possible for the International Labor Organization to adopt a covenant which in one form or other would have the effect of a treaty, dealing, for example, with the extradition of criminals. Further, could such a covenant have incorporated in it in small print a provision that any doctor graduating from any medical school in any one of the countries belonging to the United States should have the privilege of practicing in any other country, without restriction? If such a covenant were agreed to by our then President, overlooking this paragraph in small print, could it be confirmed by the members of the Senate present at a Senate session, and would that covenant then become the law of the land so that any such doctor from any such country could come into any county in Wisconsin and practice without regard to Wisconsin laws regarding the practice of medicine?

Mr. Murphy replied that Doctor Witte's understanding was definitely correct. As a matter of fact, of the roughly 120 decisions offered to the world member nations by the International Labor Organization in the past 20 years, the Senate Foreign Affairs Committee had ruled that only about 14 were of treaty dignity. The other 105 or 106 were so minor in character that they did not require handling as treaties, nor reference to the President.

Dr. A. H. Pember of Janesville then inquired what other constitutional governments, with whom our country makes treaties, have in the way of constitutional dictates similar to the proposed Bricker amendment.

Mr. Murphy replied that it was his understanding that all the parliamentary governments with which we deal, which include the governments of Western Europe, without exception already have what amounts to their own Bricker amendments. Mr. Murphy cited examples substantiating this understanding.

ACTION ON COUNCIL RECOMMENDATION

Dr. H. E. Kasten, Beloit, moved that the recommendation of the Council be adopted by a roll call vote. This motion was seconded by Dr. W. D. Stovall, Jr., Brodhead.

A supplementary report of the Credentials Committee was requested by Speaker Forkin, and was submitted by Dr. T. J. Aylward.

On motion of Doctor Aylward, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of 64 delegates and alternate delegates was accepted as the official roll.

A roll call vote was then taken resulting in a vote of 59 in favor of the Council's recommendation and five opposed. Thus, the motion was carried.

Introduction of Doctor Campbell

Speaker Forkin introduced Dr. O. J. Campbell, president of the Minnesota State Medical Association, who was in attendance at this session of the House.

Appointments to Grievance Committee

A recommendation had been made by the Committee on Grievances in its report to the House that its membership be increased from six to nine members. As its report had been accepted by the House, President Tenney announced three additional appointments to this committee, subject to approval of the House.

On motion of Dr. E. J. Schneller, Racine, seconded by Dr. E. C. Cary, Reedsville, carried, the appointments of Drs. J. L. Moffett, Platteville; C. D. Neidhold, Appleton; and C. B. Hatleberg, Chippewa Falls, to the Committee on Grievances were approved.

Exhibit on Medicine in Art

Dr. W. T. Clark, Janesville, presented a motion that the outgoing and incoming presidents of the Society cooperate to set in motion the necessary procedure for properly recording on film and in sound, if feasible, a record of the exhibit, "The Story of Medicine in Art," currently being displayed at the Milwaukee Art Institute. The motion was seconded by Dr. J. A. Enright, Milwaukee, and carried unanimously.

Retiring Officers Thanked

On motion of Dr. E. C. Cary, Reedsville, severally seconded, carried, the retiring officers were given a vote of thanks for their work on behalf of the medical profession during the past year.

Adjournment Sine Die

The House of Delegates adjourned, sine die, at 11:15 a.m.

Attendance at House of Delegates, Milwaukee October 5, 6, and 7, 1953

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	x	x	x
	J. M. Jauquet, Ashland*	a	a	a
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe, Rice Lake	x	x	x
	C. J. Strang, Barron*	a	a	a
Brown–Kewaunee–Door	J. W. Nellen, Green Bay	x	a	a
	P. F. Dockry, Green Bay*	a	a	a
	J. A. Killins, Green Bay	a	a	a
	R. M. Waldkirch, De Pere*	x	x	x
Calumet	E. W. Humke, Chilton	x	x	x
	A. C. Engel, New Holstein*	a	a	a
Chippewa	W. C. Henske, Chippewa Falls	x	x	x
	J. J. Sazama, Chippewa Falls*	a	a	a
Clark	M. V. Overman, Neillsville	x	x	x
	H. H. Christofferson, Colby*	a	a	a
Columbia–Marquette–Adams	J. H. Houghton, Wisconsin Dells	x	x	x
	J. W. MacGregor, Portage*	x	x	a
Crawford	O. E. Satter, Prairie du Chien	x	x	x
	T. F. Farrell, Prairie du Chien*	a	a	a
Dane	T. A. Leonard, Madison	x	x	x
	N. A. Hill, Madison*	x	x	x
	A. T. Smedal, Stoughton	x	x	x
	C. A. Fosmark, Madison*	a	a	a
	T. W. Tormey, Jr., Madison	x	x	x
	R. N. Allin, Madison*	x	x	a
	C. W. Stoops, Jr., Madison	x	x	x
	R. F. Collins, Madison*	a	a	a
	G. C. Hank, Madison	a	a	a
	O. S. Orth, Madison*	a	a	a
	A. A. Quisling, Madison	x	x	x
	W. A. Tanner, Madison*	a	a	a
Dodge	A. B. Kores, Beaver Dam	x	x	x
	L. W. Schrank, Waupun*	x	x	x
Douglas	Charles W. Giesen, Superior	x	x	x
	F. W. Reibold, Superior*	x	x	a
Eau Claire–Dunn–Pepin	R. J. Bryant, Durand	x	x	x
	R. C. Strand, Eau Claire*	x	x	a
Fond du Lac	H. J. Kief, Fond du Lac	x	x	x
	J. S. Huebner, Fond du Lac*	x	a	a
Forest	E. F. Castaldo, Laona	a	a	a
	B. S. Rathert, Crandon*	a	a	a
Grant	J. W. Conklin, Platteville	x	a	a
	K. L. Bauman, Lancaster*	a	a	x
Green	W. D. Stovall, Jr., Brodhead	x	x	x
	D. E. Mings, Monroe*	a	a	a
Green Lake–Waushara	D. P. Cupery, Markesan	x	x	a
	L. S. Shemanski, Wautoma*	a	a	a
Iowa	C. L. White, Mineral Point	a	a	a
	S. B. Marshall, Hollandale*	a	a	a
Jefferson	C. J. Garding, Jefferson	x	x	x
	F. A. Gruesen, Fort Atkinson*	a	x	x
Juneau	V. M. Griffin, Mauston	a	a	a
	C. L. Weston, New Lisbon*	a	a	a
Kenosha	D. N. Goldstein, Kenosha	x	x	a
	L. H. Lokvam, Kenosha*	a	a	a
La Crosse	J. J. Satory, La Crosse	x	x	x
	R. W. Ramlow, La Crosse*	x	x	x
Lafayette	D. J. Garland, Shullsburg	x	x	x
	L. J. Unterholzner, Blanchardville*	a	a	a
Langlade	F. H. Garbisch, Antigo	a	a	a
	C. E. Zellmer, Antigo*	x	x	x
Lincoln	R. G. Baker, Tomahawk	a	a	a
	K. A. Morris, Merrill*	x	x	x
Manitowoc	E. C. Cary, Reedsville	x	x	x
	R. G. Strong, Manitowoc*	a	a	a
Marathon	E. P. Ludwig, Wausau	x	x	x
	D. M. Green, Wausau*	x	x	x
Marinette–Florence	C. E. Koepp, Marinette	x	x	x
	K. G. Finegar, Marinette*	a	a	a
Milwaukee	John D. Charles, Milwaukee	a	a	a
	H. E. Bardenwerper, Milwaukee*	a	a	a
	E. R. Daniels, Milwaukee	a	a	a
	I. J. Ricciardi, Milwaukee*	a	a	a
	F. E. Drew, Milwaukee	x	x	x
	E. P. Bickler, Milwaukee*	a	x	a
	J. W. Fons, Milwaukee	x	x	x
	J. E. Conley, Milwaukee*	a	a	a
	J. G. Garland, Milwaukee	x	x	a
	J. P. Conway, Milwaukee*	a	a	a
	J. V. Herzog, Milwaukee	x	x	x
	M. C. F. Lindert, Milwaukee*	a	a	a
	G. S. Kilkenny, Milwaukee	a	a	a
	Joseph Shaiken, Milwaukee*	a	x	a
	S. W. Hollenbeck, Milwaukee	x	x	x
	P. J. Purtell, Milwaukee*	a	x	x
	L. P. Stamm, Milwaukee	x	a	x

*Alternate.

Society	Delegate	Sessions 1	2	3
	J. M. Sullivan, Milwaukee*	x	x	x
	C. A. H. Fortier, Milwaukee	x	x	x
	M. S. Fox, Milwaukee*	x	x	a
	A. J. Baumann, Milwaukee	x	x	x
	R. A. Frisch, Milwaukee*	a	a	a
	J. B. Wilets, Milwaukee	x	x	x
	R. E. Callan, Milwaukee*	a	a	a
	R. F. Purtell, Milwaukee	a	a	a
	D. W. Ovitt, Milwaukee*	a	a	a
	J. A. Enright, Milwaukee	x	x	x
	S. L. Chojnacki, Milwaukee*	x	a	x
	P. J. Niland, Milwaukee	x	a	x
	A. D. Killian, Milwaukee*	a	a	a
	P. E. Oberbreckling, Milwaukee	x	x	x
	L. A. Weisfeldt, Milwaukee*	x	x	x
	T. J. Aylward, Milwaukee	x	x	x
	D. M. Willson, Milwaukee*	x	x	x
	John M. Beffel, Wauwatosa	x	x	x
	E. A. Habeck, Milwaukee*	a	a	a
	S. A. Morton, Milwaukee	x	a	a
	Richard Foregger, Milwaukee*	a	x	a
	W. J. Houghton, Milwaukee	x	a	x
	L. R. Schweiger, Milwaukee*	a	a	a
Monroe	S. D. Beebe, Sparta	x	x	x
	Harry Mannis, Sparta*	a	a	a
Oconto	H. A. Aageson, Oconto	x	x	x
	D. M. Bailey, Gillett*	a	a	a
Oneida–Vilas	Marvin Wright, Rhinelander	x	x	x
	I. E. Schiek, Sr., Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	H. T. Gross, Appleton*	x	x	x
Pierce–St. Croix	P. H. Gutzler, River Falls	a	a	a
	O. H. Epley, New Richmond*	x	x	x
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery*	a	a	a
Portage	A. G. Dunn, Stevens Point	x	x	x
	R. H. Slater, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	W. W. Meyer, Medford*	a	a	a
Racine	E. J. Schneller, Racine	x	x	x
	L. J. Kurten, Racine*	a	a	a
	G. J. Schulz, Union Grove	x	x	x
	R. J. Schacht, Racine*	x	x	x
Richland	R. E. Housner, Richland Center	x	a	a
	D. J. Taft, Richland Center*	a	a	x
Rock	H. E. Kasten, Beloit	x	x	x
	V. S. Falk, Edgerton*	a	a	a
	E. W. Reinardy, Janesville	a	a	a
	K. L. Carter, Beloit*	a	a	a
Rusk	Howard Pagel, Ladysmith	a	x	x
	Woodruff Smith, Ladysmith*	a	x	a
Sauk	J. F. Moon, Baraboo	a	a	a
	J. J. Rouse, Reedsburg*	x	x	x
Shawano	F. W. Henke, Shawano	x	x	x
	M. H. Olson, Wittenberg*	a	a	a
Sheboygan	P. B. Mason, Sheboygan	a	x	a
	F. A. Nause, Sheboygan*	a	a	a
Trempealeau–Jackson–Buffalo	Robert Krohn, Black River Falls	x	x	x
	F. C. Skemp, Fountain City*	a	a	a
Vernon	Frank Gollin, La Farge	x	x	a
	Joseph Richter, Chaseburg*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	x	x	a
	E. D. Hudson, Lake Geneva*	a	a	a
Washington–Ozaukee	E. C. Quackenbush, Hartford	x	x	x
	P. B. Blanchard, Cedarburg*	x	a	a
Waukesha	M. J. Werra, Waukesha	x	x	x
	W. J. James, Oconomowoc*	x	x	x
Waupaca	M. A. Borchardt, New London	x	x	x
	F. J. Pfeifer, New London*	a	a	a
Winnebago	R. H. Bitter, Oshkosh	x	x	x
	G. R. Anderson, Neenah	x	a	a
	J. P. Canavan, Neenah*	a	a	a
Wood	R. E. Garrison, Wisconsin Rapids	x	x	a
	K. H. Doege, Marshfield*	x	x	x
General Practice	G. E. Forkin, Menasha	x	x	x
	J. A. Grab, Sun Prairie*	a	a	a
Internal Medicine	M. A. Hardgrove, Milwaukee	a	a	a
	R. N. Allin, Madison*	x	x	a
Neurology and Psychiatry	E. D. Schwade, Milwaukee	x	x	x
	Harry Tabachnick, Milwaukee*	a	a	a
Obstetrics and Gynecology	T. A. Leonard, Madison	x	x	x
	M. M. Hipke, Milwaukee*	a	a	a
Ophthalmology and Otolaryngology	A. H. Pember, Janesville	x	x	x
	E. J. Zeiss, Appleton*	a	a	x
Orthopedics	D. W. McCormick, Fond du Lac	x	x	a
	F. G. Gaenslen, Milwaukee*	a	a	a
Pathology	Gorton Ritchie, Milwaukee	x	x	a
	R. S. Haukohl, Milwaukee*	a	a	x
Pediatrics	K. J. Winters, Wauwatosa	x	x	x
	F. J. Mellencamp, Milwaukee*	a	a	a
Radiology	W. T. Clark, Janesville	x	x	x
	R. L. Troup, Green Bay*	a	a	a
Surgery	J. M. Sullivan, Milwaukee	x	x	x
	M. G. Rice, Stevens Point*	a	a	a

*Alternate.

Minutes of the Council Meeting, Milwaukee October 4, 1953

1. Call to Order

The Council was called to order by Chairman Arveson at 3:00 p.m., Sunday, October 4, at the Hotel Schroeder, Milwaukee.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, and Zellmer and Chairman Emeritus Gavin.

Also present were President Griffith; President-Elect Tenney; Speaker Forkin; Vice-Speaker Fons; Treasurer Weston; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association; Drs. W. D. Stovall and D. H. Witte, delegates to the American Medical Association; Dr. J. M. Sullivan, chairman, Committee on Public Policy; Dr. C. N. Neupert, state health officer; and, for part of the meeting, Dr. M. J. Musser, chairman, Committee on Civil Defense and Medicine; Dr. L. O. Simenstad, chairman, Reference Committee on Reports of Officers; and Dr. Charles Fidler. Guests representing the Minnesota State Medical Association were Dr. Arnold Swenson, chairman of the Council, and Mr. R. R. Rosell, St. Paul, executive secretary.

Staff members present were C. H. Crownhart, secretary; Roy T. Ragatz, assistant secretary; Earl Thayer, director of public information; R. B. Murphy, legal counsel; Dr. R. C. Parkin, medical advisor; Miss Darlene Davie, administrative assistant, "March of Medicine"; and Miss Joan Pyre and Miss Jean McGruer of the Society's office.

3. Commendation of President Griffith

On behalf of the Council of the State Medical Society, Chairman Arveson praised the work of President J. C. Griffith during the year and thanked him for his service.

4. Approval of Minutes

The minutes of the May and August 1953 meetings could not be published until the October and November issues of the Journal, but were submitted to the Council by mail in page proof and mimeographed form. On motion of Doctors Kasten–Zellmer, carried, the minutes of the May meeting, as published in the October Journal, and the August meeting, as published in the November issue of the Journal, were approved.

5. "March of Medicine"

At an earlier meeting the Council had requested periodic reports of various Society activities, chiefly those carried on at the staff level rather than under the close supervision of a committee.

The radio program "March of Medicine"—its history, its present status, and a summary of its activities—was presented by Dr. Robert C. Parkin, part-time medical adviser to the State Medical Society and director of the "March of Medicine," and Miss Darlene Davie of the staff.

Doctor Parkin discussed his supervision of the medical aspects of the program and his participation in the recording of them; parts of programs actually recorded were played, and Miss Davie reported on preparation of the initial script, the answering of fan mail, and other activities connected with the program.

On motion of Doctor Ekblad, variously seconded and carried, the Council commended the presentation and recommended that it be repeated in the House of Delegates. A more detailed report will be found in the proceedings of the House of Delegates, printed in another section of this issue of the Journal.

6. Report of the Committee on Military Medical Service

The report of the Committee on Military Medical Service was presented to the Council by Dr. F. L. Weston, chairman. On motion of Doctors Galasinski–Ekblad, the report was approved for submission to the House of Delegates. The report is printed in the House of Delegates proceedings in another section of this issue of the Journal.

At this time the secretary read the following letter from Col. Bentley Courtenay, in appreciation of the work done by Doctor Weston and others:

STATE HEADQUARTERS—SELECTIVE SERVICE

1 October 1953

Dear Dr. Arveson:

The recent announcement of the probable suspension of the doctor draft until July 1954 gives me an opportunity to review what has occurred since 1950, to take stock of the present situation, and to plan for the future.

I find that nearly 100 Wisconsin physicians entered military service as a direct result of the draft. Many more entered voluntarily during the same period. In fact, volunteering during recent months has provided the armed forces with so ample a supply of reserve personnel as to force a temporary suspension of the draft. This situation did not occur by accident, even though its extent may have been underestimated by the Department of Defense. It would appear that the younger members of your profession are becoming reconciled to the probability that military service will become an integral part

of their careers. We in Selective Service are willing to admit that we may have provided some part of the education which has resulted in this understanding, but it is a certainty that we could not have accomplished this feat without the assistance and backing of your entire profession.

The representatives of your Society who have directed and participated in the activities of the Wisconsin State Advisory Committee—your councilors who have provided able and loyal assistance to the Committee and the Society's staff members who have administered the countless projects associated with the draft—all deserve special commendation for their effective and worthy public service.

I trust that your Council will concur with me in acknowledging that Dr. Frank L. Weston, the members of his Committee, your Councilors, and Mr. Earl R. Thayer have all made a most significant contribution to the operation of an unprecedented military procurement program. It is my hope that we of the Selective Service System may continue to enjoy the benefits of their advice and counsel.

I believe that we should maintain a state of readiness in our respective operations so that a resumption of the draft will impose no extra hardship upon the members of your profession or the institutions with which they are affiliated. This can best be accomplished by maintaining the cordial and effective relationship between my headquarters and the State Advisory Committee which accounts for our joint and mutual success.

Yours very truly,
/s/ Bentley Courtenay
Colonel, JAGC
State Director

7. Student Loan Fund

The secretary reported that in accordance with action taken in 1952 three loans had been made to students at the University of Wisconsin Medical School and the Marquette University School of Medicine.

The audited report of the Student Loan Fund was presented for review by Council members. It was reported that the annual meeting of the Board of Trustees had been waived, and for that reason Council action on the report and other matters concerning the Student Loan Fund was postponed until such meeting could be held.

8. Committee on Civil Defense and Medicine

Dr. M. J. Musser, chairman, presented the annual report of the Committee on Civil Defense and Medicine.

On motion of Doctors Dessloch–McCarey, carried, the Council expressed its appreciation to Doctor Musser and on further motion of Doctors Kasten–Hill, carried, recommended that the report be transmitted to the House of Delegates. The report is presented in its entirety in the proceedings of the House, printed in another section of this issue of the Journal.

9. Proposed Public Relations and Educational Program, Pharmacy and Medicine

Dr. J. M. Sullivan, chairman, Committee on Public Policy, reported on a meeting of his committee with a committee representing the Wisconsin Pharmaceutical Association to explore ways and means by which the inter-professional relations of the membership of the two organizations could be improved. Doctor Sullivan reported that another meeting would be held at a later date. No action was taken.

10. Inquiries Concerning Eligibility for Membership in County Medical Societies

The secretary reported to the Council that inquiries are received from county societies from time to time as to whether an individual physician meets the requirements of the State Medical Society of Wisconsin for membership in the county society. He stated that in answer to that type of inquiry the usual procedure is to provide the county medical society with any factual information on the physician available in Society files, but no opinion of him; to remind the county society that jurisdiction on election to membership is strictly within the county society; and to inform the county society that an inquiry may be referred to the Council for an official opinion, but specific action must be taken in that respect.

On motion of Doctors Bell–Fox, carried, Council approval was given to the present method of handling such inquiries.

11. American Medical Education Foundation

The most recent report of the AMEF was distributed at the time of the meeting. No action was taken and the subject was tabled to the next meeting.

12. Dr. E. E. Kidder

The illness of Dr. E. E. Kidder, Ninth District Councilor, was reported to the Council, and on motion of Doctors Heidner–Wegmann, carried, the secretary was directed to send him an expression of sympathy and appreciation for his work with the Council.

13. T. A. Hardgrove, D. D. S.

The following statement was offered by Doctor Galasinski, and adopted on motion of Doctors Dessloch–Hill, unanimously carried:

> Timothy A. Hardgrove, of Fond du Lac, Wisconsin, a doctor of dental surgery—
>
> Wisconsin born, your professional education obtained from the Chicago College of Dentistry —you have for more than 50 years served the general public, your patients, and the dental and medical professions with loyalty and distinction.
>
> A member of many professional organizations —local, state, and national—you have achieved

singular recognition as a distinguished practitioner, an imaginative dental researcher, and as a leader among men.

For these many reasons, the Council of the State Medical Society, in formal meeting this fourth day of October 1953, engrosses in the permanent records of the State Medical Society of Wisconsin your name and your achievements, that those who in future years are dedicated to serve the health of their fellow men may seek to emulate you, our distinguished friend.

14. Bricker Amendment

At the 1952 session of the House of Delegates of the American Medical Association in Denver, a resolution endorsing the amendment proposed by Senator Bricker was introduced by Dr. Willard A. Wright, North Dakota, and adopted. Subsequently, at the New York Annual Meeting in June 1953, this position was reaffirmed. It expressed an opinion earlier stated at the North Central Medical Conference, Wisconsin participating, held in November 1952, to the effect that international treaties and covenants should not supersede the Constitution of the United States or the police power of the states.

After discussion the Council unanimously voted to support the Bricker resolution. The Council's recommendations will be found in the proceedings of the House of Delegates, printed in another section of this issue of the Journal. (See also minutes of Council meeting held October 7, 1953, which follow.)

15. Retirement Program for State Medical Society Employees

Details of a retirement program for employees of the State Medical Society were reviewed, and on motion of Doctors Kasten–Ekblad, carried, the subject of the retirement program was delegated to the Audit and Budget Committee to perfect and install in 1954.

16. Current Developments, Blue Shield of Wisconsin

Doctor Dessloch, chairman of the Commission on Prepaid Plans, stated that in addition to the "voluminous annual report in the Delegates Handbook, current developments in Blue Shield are such that they are far reaching and extensive." He reviewed briefly the matters of renegotiation of the agency contract, which is currently under way with Blue Cross, and the possibility of Blue Cross rate increase. Doctor Dessloch also reported that the recently certified 1952 financial statement indicated that Wisconsin Physicians Service is in "good condition."

17. Report of the Interim Committee

The Interim Committee reported the following actions for consideration of the Council:

(1) *Council Award*

The secretary reported advice received to the effect that one of the recipients of the Council Award would not attend the Annual Dinner because of illness and that the Interim Committee recommends Council approval to presenting the award in absentia.

On motion of Doctors Zellmer–Hill, carried, such approval was given.

(2) *Student AMA representation at House of Delegates*

The representatives of the Student American Medical Association in Wisconsin have suggested that the House of Delegates of the State Medical Society follow a policy similar to that of the House of Delegates of the American Medical Association, under which representatives of the Student American Medical Association are invited by formal resolution to attend meetings of the House of Delegates and its various reference committees as official representatives of the SAMA, but without voting privileges.

The Interim Committee recommends to the Council that this matter be referred to the House of Delegates, with the recommendation that such action is appropriate and will further effectuate the purposes of the Student American Medical Association.

On motion of Doctors Dessloch–Galasinski, carried, the recommendation was approved for referral to the House of Delegates.

(3) *Society's contribution to cost of Blue Shield–Blue Cross program for its employees*

This program was first installed in 1947, with the Society and its agencies paying the full cost. Blue Cross later issued its comprehensive contract, which was placed in effect on Society employees, with the additional cost being borne entirely by the employees. Installation of the Society's new A and B program further complicated the problem of how to determine the proration of costs.

First-day surgical benefits have recently been added for those eligible and medical care benefits have been extended to 70 days.

Because we are working from the base that the Society and agencies pay or contribute to the cost the *amount* that the old Blue Cross standard and the old Blue Shield contracts cost, the Society is paying a variable percentage. The minimum is 61 per cent for some employees and the maximum is 74 per cent for others.

The Interim Committee believes that the Society should act to make its contribution a percentage standard for all employees and suggests 75 per cent for that purpose.

The second recommendation has to do with date of eligibility for the new employees. At the present time, they are eligible on the first of the month following their first 30 days of employment. Because new employees are on a probationary period for 90 days, and because that probationary period is sometimes extended when there is doubt as to an employee's ability, it is recommended that new employees become eligible for enrollment after completion of the probationary period.

On motion of Doctors Wegmann–McCarey, carried, the Council approved both recommendations concerning the Blue Shield–Blue Cross program for employees.

(4) *Nominees to the Governor for appointments to state boards*

By statute the State Medical Society is invited to submit to the Governor nominees for his consideration for appointment to the State Board of Medical Examiners and the State Board of Nursing. Both statutes are of recent origin.

The Interim Committee recommends that on such occasions, when there are terms expiring and nominations to be made, the matter be scheduled on the Council agenda well in advance of the time when such nominations should be offered. It is believed that it is appropriate that there be prior consideration by the Interim Committee to allow for such individual problems as geographic distribution, type of practice, and the interest of various individuals in the field to be served.

On motion of Doctors Kasten–Hill, carried, the recommendation of the Interim Committee was approved.

(5) *Veterans Medical Service Agency*

The secretary reported on current developments in the Veterans Administration and on a directive of the Bureau of the Budget to effect certain economies in the VA, including a reduction in the appropriation for the home town care program. He stated that no reduction in the proper level and quality of care for the veteran with a service connected disability should be accepted by the medical profession without protest, but that in the meantime certain steps had been taken to decrease administrative costs of this agency of the State Medical Society.

The Interim Committee reviewed the problem, approved the secretary's administrative action, and recommended report to the Council.

On motion of Doctors McCarey–Casper, carried, Council approval was also given to such administrative procedures.

Conclusions

Other matters which require further study by the committee before detailed reporting to the Council involve reorganization to broaden the base of the Student Loan Fund and the advisability of amending the By-Laws to permit the Council to determine itself the date of its annual meeting, inasmuch as in 1955 the House of Delegates will meet in April.

18. Yearly Schedule of Meetings

The secretary directed attention of the Council to a proposed chart of meeting dates set for the ensuing year. The schedule included dates for the Interim Committee and Council, Commission on Prepaid Plans, Commission on State Departments, postgraduate teaching clinics, AMA meetings, and others. Unanimous approval was given to such a schedule and the staff was directed to have it printed in final form for distribution.

19. Date of November Meeting

The next meeting of the Council was scheduled for November 21 and 22, with the Interim Committee meeting before the Council session.

20. Adjournment

The meeting adjourned at 6:30 p.m., Sunday, October 4, 1953.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

ELECTROCARDIOGRAPHIC INTERPRETATION FOR GRADUATE PHYSICIANS

A 12-week course in electrocardiographic interpretation for graduate physicians will be given at the Michael Reese Hospital in Chicago beginning February 3. Conducted by Louis N. Katz, M. D., Director of the Cardiovascular Department, Medical Research Institute, and associates, the class will meet on 12 consecutive Wednesday evenings from seven to nine o'clock.

Further information and a copy of the lecture schedule may be obtained on application to Mrs. Rivian Lewin, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

Minutes of the Council Meeting, Milwaukee October 7, 1953

A special meeting of the Council having been called, the meeting was called to order by Chairman Arveson at 7:30 a.m., October 7, 1953, at the Hotel Schroeder, Milwaukee.

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Heidner, McCarey, Fox, Arveson, Ekblad, Galasinski, Casper, and Zellmer. Also present were President Griffith; President-Elect Tenney; Treasurer Weston; Speaker Forkin; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association; and Doctors Stovall and Witte, delegates to the American Medical Association. Specially invited guests included Drs. W. C. Henske, E. C. Cary, W. A. Fischer, T. W. Tormey, Jr., J. M. Sullivan, R. E. Garrison, Robert Krohn, C. W. Stoops, Jr., E. P. Ludwig, C. E. Koepp, and O. E. Satter; and Mr. Joseph E. Stetler of the American Medical Association.

The staff was represented by C. H. Crownhart, secretary; Earl Thayer, director of public information; Robert B. Murphy, legal counsel; and Miss Joan Pyre and Miss Jean McGruer of the Society's office.

Chairman Arveson asked that the secretary present the problem before the meeting.

The secretary explained that at the October 4, 1953, Council meeting, one of the matters before it was the Bricker resolution, relating to the matter of international treaties and covenants and domestic law.

The Council heard a detailed explanation of the resolution and its contemplated effect. The involvement of health issues was illustrated. The Council then adopted a special report transmitted to the House of Delegates that same day, urging the House to take action consistent with that of the American Medical Association and other organizations.

The report was referred to the Reference Committee on Resolutions, which, after hearing, reported to the House of Delegates its recommendation that the subject be handled through the Council, which is in frequent session and which is the executive body of the House. The reference committee reported its belief that this would provide greater flexibility and would permit the specifics as well as the generalities to be considered on any occasion.

At this time the House of Delegates took action recommending to the Council that the resolution concerning the Bricker amendment be tabled.

The secretary expressed his opinion that by this action the subject had been referred to the Council with an expression of opinion by the House that the Council table the matter. This, in effect, constituted the Council a reference committee of the House.

There was then detailed consideration of the subject and of the procedure to be followed. Those taking part in the discussion included Doctors Arveson, Forkin, Cary, Fox, Koepp, Ekblad, Galasinski, Stovall, Costello, Henske, Stoops, Satter, Krohn, Koepp, Kasten, and Weston; and Messrs. Stetler, Crownhart, and Murphy.

After discussion, and on motion of Doctors Casper–Kasten, carried, the following report was then authorized to be transmitted to the House meeting later that day:

At the first session of the House, October 5, a supplementary report of the Council recommended to this House of Delegates that it should follow and support action taken on two occasions by the House of Delegates of the American Medical Association in support of the Bricker resolution, proposing a constitutional amendment placing some limits on the treaty powers of governmental officials.

This action by the Council was by unanimous vote taken after careful consideration of the subject and consistent with the action of the House of Delegates of the American Medical Association.

At its second session the House of Delegates of the State Medical Society referred the subject back to the Council, with the recommendation that the whole matter be tabled.

The Council met in special session this morning.

It cannot, in good conscience, as a Council, and its members cannot, in good conscience, as American citizens, do other than bring this subject before the House of Delegates, that each member of the House may be fully cognizant of the circumstances which have led to its support by the American Medical Association.

At this point, Mr. Speaker, by formal action of the Council, Mr. Murphy, attorney for the State Medical Society, and Mr. Joseph Stetler, secretary of the legislative committee of the American Medical Association, will discuss the subject, so that the House may have the benefit of the same background and explanation that the Council had before it acted favorably in the matter on October 4. After their discussion, I shall present the recommendation of the Council that the House of Delegates, by roll call, formally vote upon this important issue.

Conclusion

Mr. Speaker, the Council, acting as reference committee for the House, recommends that the House, by roll call, support the position of its parent organization, the American Medical Association, and record its approval to the principle expressed in the Bricker resolution.

The meeting adjourned at 8:30 a.m., Wednesday, October 7, 1953.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	10:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	3:15 p.m.
WHHI	Highland	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WCAN	Milwaukee	Sunday	6:45 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:45 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	5:45 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Monday	4:15 p.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Tuesday	7:15 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Saturday	10:15 a.m.
WSAU	Wausau	Monday	4:15 p.m.
WBKV	West Bend	Saturday	11:00 a.m.
WHLA	West Salem	Saturday	10:30 a.m.

Minutes of the Council Meeting, Madison November 21 and 22, 1953

1. Call to Order

The Council was called to order by Chairman Arveson at 2:45 p.m., Saturday, November 21, at the Loraine Hotel, Madison.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, and Zellmer; Past-President Griffith; and Chairman Emeritus Gavin.

Also present were President Tenney; Vice-Speaker Fons; Doctors Stovall and Witte, delegates to the American Medical Association; and Dr. T. W. Tormey, Jr., chairman of the Commission on State Departments (Saturday only).

Staff members present were C. H. Crownhart, secretary; Robert B. Murphy, legal counsel; Earl R. Thayer, director of public information; Roy T. Ragatz, assistant secretary (Sunday only); and Miss Joan Pyre (Saturday only) and Miss Jean McGruer of the Society's office.

3. Councilor Requests, New Business

At a previous meeting of the Council, it was suggested that Councilors be given the opportunity to request the addition of a subject not already on the agenda for discussion. Doctor Kasten requested discussion of the current status of social security legislation as it affects the medical profession.

4. Meeting of American Medical Association, December 1953

By prior action the Council has been directed to schedule meetings in the months before the two sessions of the American Medical Association, to provide an opportunity to express to the Wisconsin delegates opinion on subjects to be discussed and to give them direction as to the position of the State Medical Society with respect to these subjects.

At the time of the Council meeting three resolutions to be offered at the AMA meeting were known —one by Iowa, regarding fee splitting, the second by Alabama, respecting a comprehensive study of cultism; and the third by Michigan, concerning Veteran Administration care of non-service-connected disabilities. After considerable discussion of the three resolutions, a unanimous vote of confidence was given the AMA delegates, with instructions to use their discretion in any action requested on the resolutions.

In addition, it was reported that a number of other subjects would be brought up at the AMA meeting in St. Louis, including the privilege tax by hospitals (the practice of requiring physicians using a hospital to pay to it a percentage of fees received from their patients hospitalized there, and of which there was criticism by the House in 1952); several matters in the field of industrial health, such as the extension of curative medical services into rehabilitation and replacement, the problem of lost-time illness, and complaints that sick certification is uncritical, especially as to unnecessary prolongation of absence due to sickness and surgical procedure, and the development of a code of ethics for the physician in industry; the subject of allowance as tax deductions expenses of a physician attending postgraduate courses, brought out in the recently decided Coughlin case; the development of a uniform medical licensing act among all states; a recent opinion of the attorney general of Ohio which concluded that in that state a corporation (hospital) may not directly or indirectly, whether or not organized and operated for profit, practice a profession by hiring licensed members of such profession to do the actual professional work involved; and, finally, the subject of malpractice insurance rates.

5. Revised Wisconsin Corporation Code

Mr. Murphy, legal counsel for the State Medical Society, reported to the Council on the new nonstock corporation law enacted in the 1953 session of the legislature. He said it is a modern and useful law which "contains a number of provisions of present or potential value to the State Medical Society." He stated that its provisions are fair and much more complete than those under which corporations now operate, and recommended that the Council consider electing to come under the act during the next two years. He pointed out that the statute permits such election, but requires formal action. It was recommended that action be withheld until 1954, and on motion of Doctors Bell–Fox, carried, the subject was directed to be taken up at the February or May 1954 meeting.

6. T. A. Hardgrove, D.D.S.

Chairman Arveson read to the Councilors a letter of thanks and appreciation from Dr. T. A. Hardgrove, with respect to the statement of recognition presented him at the time of the October 1953 meeting.

7. Report of the Secretary

(a) *Program of Pharmacy and Medicine*

On behalf of Dr. J. M. Sullivan, chairman, Committee on Public Policy, who was not able to attend the meeting, the secretary presented the following report with respect to the proposed public relations

and educational program of pharmacy and medicine:

For more than four years, specifically, and even antedating that, the Wisconsin Pharmaceutical Association has been critical of certain physician practices in Wisconsin. For the most part these differences have been reconciled.

Both the State Medical Society and the Wisconsin Pharmaceutical Association have worked jointly on many occasions concerning problems arising out of telephoned orders, the necessity of directing or authorizing "repeat refills," etc.

The area of misunderstanding that still exists relates, on the part of the Pharmaceutical Association, to the matter of clinic pharmacies and physician dispensing.

The WPA does not believe in clinic pharmacies. Some of these are operated by pharmacists wholly independent of the clinic; some are operated through the clinic organization; and some by a third party organization representing both physician and pharmacy interest.

In substance, the position of the pharmacist is that a clinic pharmacy tends to restrict patients to that facility, avoids free choice of pharmacy, and obstructs the opportunity of the pharmacist to further himself as a member of an independent profession.

Physician dispensing is another matter.

The pharmacist concedes the right of a physician to dispense to his own patients if he chooses to do so. The pharmacist claims, however, that that "right" is a wholly personal one, no essential aspect of which may be delegated to employees within physicians' offices.

As far as the Committee on Public Policy is concerned, there are other views which must be considered. The problem presented by the Wisconsin Pharmaceutical Association requires analysis in light of other public needs.

In the case of clinic pharmacies, the committee feels that other than purely economic matters enter into their establishment. Group practice envisions the ability to provide patients with a total service in so far as ambulatory needs are concerned. As clinics have become established in the north central area of the United States, their objectives have evolved from a mere association of physicians. General practice and the specialties have been included. Diagnostic services have been expanded, particularly in the field of x-ray. Physical therapy is quite frequently a division of the clinic service.

The services of a doctor of dental surgery constitute an important part of many of these organizations, and individuals with limited licenses in ancillary fields are frequently included in the clinic personnel.

It is a consequent and natural development that clinic organization provides a further service—that of a dispensary for the more commonly used medications and supplies. Including these services in a clinic organization no more affects free choice of pharmacy than the inclusion of dental services affects free choice of dentist.

Patients are under no compulsion to engage the services of the clinic. It must be presumed that in seeking its services they exercise complete freedom of choice, and may discontinue at any time.

The problem of dispensing is not, in itself, dissimilar. In choosing a medical career, the physician does not intend to become a pharmacist. Pharmacy includes much more than mere dispensing. Pharmacy is a profession unto itself and involves other technics than the simple task of dispensing a prepared product of rather common availability with properties well known to the professions.

Physicians recognize and promote the practice of pharmacy as a profession. The mere fact that individual physicians may do some part of the practice of a pharmacist is not lack of cooperation with or lack of recognition of the latter, for pharmacy is historically a part of the practice of medicine, rather than the converse.

All of these considerations prompt the Committee on Public Policy to recommend that it would be premature and obviously poor interprofessional relations for the two associations to engage in "joint studies" which might well be considered "investigations."

What seems to be more logical and better advised is that this Committee ascertain why it is that some physicians do dispense. Is it a sense of obligation to the patient because of the non-availability of adequate services locally? What component parts are there in the definition of the word "availability?" Does it include, beyond reasonable proximity, not alone a "drug store" but a pharmacist on duty during those hours when patients may be expected to present the prescription of the physician? Does it include a reasonable stock in trade?

Is the fact of physician dispensing in a particular area developed out of a long-standing tradition? Can it be expected that a physician who dispenses should discontinue that practice when a pharmacist does become available within that particular area? If so, does the converse hold that when a pharmacist is no longer available, a physician should institute, or re-institute, the practice of dispensing?

What considerations enter into the distribution of the pharmacist? Is their "production" adequate to satisfy needs, or is there a demand that cannot be met by present-day educational facilities?

The Committee on Public Policy believes that the profession of medicine should begin at the beginning rather than with end results. To engage in limited joint studies is putting the cart before the horse. It will tend to examine a particular situation which may or may not be representative of the whole.

And at this point it must be admitted frankly that no careful analysis is available to this committee, except as partisans express their views, substantiated only by individual examples.

Therefore, the committee recommends to the Council that it grant authority for studies along the lines indicated here, and that it be understood that the perfection of technics for engaging in such studies, and in seeking facts upon which to base conclusions, is not a matter that can be completed overnight.

The committee also reiterates its willingness to have the Wisconsin Pharmaceutical Association present to it any special problems involving individual situations in which the committee might be of some assistance.

This statement is prepared jointly by the chairman of the committee and the secretary of the Society, and while its recommendations are those of the committee, the committee members have had no opportunity to review the rationale supporting its recommendations.

On motion of Doctors Bell–Kasten, the report was laid over for action at the Sunday session of the meeting, and at that time, on motion of Doctors Heidner–Fox, carried, the report was approved by the Council.

(b) *Wisconsin Veterans Medical Service Agency*

At the October meeting, the Secretary reported that certain steps had been taken to decrease administrative costs in the Veterans Medical Service Agency because of advice from the Veterans Administration that economies were to be effected in that agency. The secretary reported subsequent advice contained in a letter from Doctor Sebastian of the Veterans Administration, in which it was said, "A review of our fee basis treatment funds at the close of October leads us to believe that treatment will not be deferred or denied because of lack of funds during the remainder of this quarter."

On this advice, Council approval was given to the reinstatement of certain of the expense items which had been cut in October.

(c) *Woman's Auxiliary*

By request at the time of the May Council meeting, the secretary reported on the activities of the Woman's Auxiliary in which there is actual Society participation and assistance. It was reported that the actual cost to the State Medical Society is approximately $2,500 a year, including the time of personnel delegated to assist the Auxiliary, the printing costs in connection with the *Badger Doctor's Wife* and the nurse recruitment program, and expenses for supplies, travel, and meetings, including the Annual Meeting.

(d) *American Medical Education Foundation*

The secretary reminded Councilors of their October action to lay over until the November meeting the matter of contributions to the AMEF, and reports were distributed which listed the AMEF record of Wisconsin contributors. That report listed 81 individuals contributing $2,255 for the period January 1 through December 31, 1952; and 22 individuals contributing $1,350 for the period January 1 through October 31, 1953.

Mr. Crownhart said he felt that the matter of soliciting contributions to the Fund was more a problem to be handled within the profession itself than at the staff level, but offered the assistance of the staff to put a program into operation.

Doctor Heidner pointed out that contributions could be made through the AMEF with the request that they be directed to an individual school of choice, and that full credit would be given, in that manner, to both the AMEF and the individual school. He reported that Wisconsin is far down on the list of contributions and urged Councilors to remind physicians in their districts of the manner in which contributions may be made.

8. Index of Official Council Actions

A cumulative index of official actions of the State Medical Society, as represented in the Council and in the House of Delegates, was submitted to the Council. The index included actions involving basic policy, management details, and procedure from January 1942 through June 1953 and will be kept up to date by annual redistribution. It was felt that the index would be of continuing value to Councilors and officers, and particularly helpful to new officers and Councilors.

9. Joint Commission on Accreditation of Hospitals

Councilor Bell requested discussion of the effect of new regulations on hospital staff organization, as adopted by the Joint Commission on Accreditation of Hospitals, and there was particular discussion of regulations concerning general practitioners and attendance at monthly staff meetings.

The following excerpt from the Newsletter, October 1953 GP (the monthly journal of the American Academy of General Practice) was brought to the attention of Councilors:

The Joint Commission on Hospital Accreditation has acted to clear away some of the misunderstanding over its new regulations on hospital staff organization. The commission has adopted the Academy's Manual on General Practice Departments as a guide for its field inspectors, and provision for such departments is made in Sec. II, E, of its "Standards for Accreditation."

In some quarters there has been complaint that the commission's regulations would demand that general practitioners attend monthly staff meetings of all of the clinical departments in which they hold privileges. But Dr. Edwin L. Crosby, the commission's able director, has stated *this is not required.* In hospitals where a general practice department exists, general practitioners are active members of the staff through appointment to that department. They must attend 75 per cent of its meetings. But, in the other clinical departments, they may be similar to a member of the courtesy staff and thus be relieved of active staff duties. They would vote only in the general practice department and regular staff

meetings, not in clinical departments where they have been accorded courtesy privileges.

There was considerable discussion of the subject, with most of the councilors describing procedures followed in hospitals of which they were staff members, and at the request of Doctor Bell, the subject was laid over for further consideration at a future meeting.

10. Management Services

In a special report the secretary discussed the development in recent years of various types of management organizations created primarily to serve professional offices. The services included in such organizations are accounting, budgeting, collection advice on outstanding accounts, and periodic check of office procedures. In the opinion of the staff these organizations have a place and there is a need for them.

The subject was assigned to the staff some time ago for study and possible recommendations. This study brought out the facts that some of these organizations operate under trade names, that none of them is subject to any licensing or bonding laws of the state, and that staff members themselves are not subject to such laws. The study led to the conclusion that no organization should represent itself as prepared to give "professional" advice unless it is actually qualified in a professional field and that organizations having such intimate contact with records and procedures should be in a position to virtually guarantee competence.

In light of these considerations it was recommended that the staff develop a series of standards under which an organization may secure approval of the State Medical Society for advertising in *The Wisconsin Medical Journal*, exhibit at the Annual Meeting, and represent itself as approved.

On motion of Doctors Hill–Heidner, carried, the staff was authorized to proceed with its study and with the development of standards, to be submitted to the Council for further study at a later date.

11. Annual Meeting of Council, By-Law Amendment

In view of the fact that the Annual Meeting of the State Medical Society will be held in late April 1955, it was brought to the attention of the Council that the date of its annual meeting, now required in February under Chapter VI of the By-Laws, be changed. It was suggested that under a revised by-law the Council be permitted to fix its own date for its annual meeting.

On motion of Doctors Kasten–Casper, carried, revision of the by-laws to effect this change was authorized for transmission to the House of Delegates.

12. Time Schedule, 1954 Annual Meeting

Action was taken in the 1953 session of the House of Delegates, directing the Council to consider scheduling 1954 House sessions and reference committee meetings so as not to conflict with the scientific sessions, in order to permit participation of the general membership in the open sessions of the reference committees and attendance at one or more House sessions.

As a result of this action, a proposed time schedule was submitted for consideration of the Council. In discussing the proposed schedule it was pointed out that the timing would create difficulty in arranging for the golf tournament, and there was considerable discussion as to rearrangement of the schedule.

On motion of Doctors Fox–Ekblad, carried, the Council directed Mr. Ragatz and Doctor Bernhart to revise the schedule and work out arrangements which would be acceptable.

13. Report of the Interim Committee

The Interim Committee, at its meeting on November 21, considered a number of matters and offers the following recommendations:

(1) *Special Advertising Opportunity—Wisconsin Medical Journal*

Inquiry has been made as to whether the Journal can accept a four-page spread, conditioned on its exact location in the middle of the Journal, the position now occupied by the Forum. If the advertising should be accepted, it would mean several thousand dollars of income annually.

While this is preferred location, similar to front-page advertising now carried, the Interim Committee sees no reason why the advertising should not be accepted if offered, and it recommends that the Council issue such recommendation to the staff.

On motion of Doctors Casper–Hill, carried, the recommendation was approved by the Council.

(2) *Resignations*

(a) Because of acceptance of another committee appointment involving a considerable amount of work, Doctor Moffett, Platteville, has resigned from the Wisconsin Veterans Medical Service Agency. Upon recommendation of the Interim Committee, the chairman of the Council has appointed Dr. Charles E. Koepp, Marinette, to fulfill the unexpired term (1958) of Doctor Moffett.

(b) Dr. T. L. Tolan, Milwaukee, has asked to be relieved from his appointment to the Commission on State Departments and as chairman of the Division on Hearing and Visual Defects. The Interim Committee nominates Dr. Maxine Bennett, Madison, to fill this position.

(c) Dr. J. D. Steele, Milwaukee, also asked to be relieved from his appointment to the Commission on State Departments, and as chairman of the Division on Tuberculosis; the Interim Committee understands that Doctor Steele asked to be relieved from this assignment because of other assignments which have come to him in recent months. The Interim Committee recommends Dr. H. A. Anderson, River Pines Sanatorium, Stevens Point, as his successor.

Nominations to the Commission on State Departments require Council action, and the appointments of Doctor Bennett and Doctor Anderson were unanimously approved.

(d) Membership on the Commission on Prepaid Plans is by appointment of the chairman of the Council. Dr. W. C. Stewart, Kenosha, appointed for a term expiring in 1955, has resigned from that position, stating his reason to be staff "condemnation" of the medical profession in Racine and Kenosha counties. The secretary pointed out to Doctor Stewart in reply to his resignation that the staff has not engaged in condemnation of the medical profession of those two counties, but has sought ways of eliminating such obstacles as have prevented the physicians in that area from participating in the prepaid plans.

The Interim Committee has been provided with a copy of Doctor Stewart's resignation and the secretary's reply, and it recommends acceptance of Doctor Stewart's resignation.

On motion of Doctors Bell–Ekblad, carried, the recommendation to accept Doctor Stewart's resignation was approved.

(3) *Miscellaneous*

The Interim Committee discussed development of the Historical Section of the State Medical Society; recommendations will be submitted at a later date. The committee plans to meet with representatives of the Wisconsin Dental Association before the next Council meeting, carrying out liaison with that group established more than two years ago. It reviewed other mechanisms of the office and concludes this report with the following specific recommendations:

(4) *Constitution and By-Laws of Sections*

Under Chapter XII, relating to sections, qualifications for membership are subject to approval by the Council; the officers constitute the executive committee, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. No section has the power to bind the Society without prior approval by the House, or by a majority of the members of the Council when the House is not in session.

Society records do not disclose that the Constitution and By-Laws of any of the sections have been reviewed and approved by the Council. The Interim Committee therefore recommends that the staff be directed to secure such relevant material as may be found necessary and that the Interim Committee be authorized to review this material, with the possibility of offering specific recommendations to the Council.

On motion of Doctors Heidner–Hill, carried, the Council approved the recommendation to secure and study material concerning sections.

(5) *1955 AMA Rural Health Conference in Milwaukee*

Established about five years ago, this national conference will, for the first time, be held in Wisconsin in 1955. It is unlikely that Wisconsin will be a host state for some years thereafter. The Interim Committee recommends to the Council that it approve discontinuing all public health conferences of which the State Medical Society is sponsor in 1954, and that emphasis be placed in all ways possible upon the 1955 rural health conference. If feasible, the annual meeting of the Council and of other bodies concerned with management of Society affairs should be scheduled during the course of the 1955 conference.

The recommendation was approved by the Council on motion of Doctors Zellmer–Galasinski, carried.

(6) *Student American Medical Association*

In the organization of this body, chapters exist at Marquette and at Wisconsin and each chapter has an adviser from the State Medical Society. Representation by these chapters is invited at the annual meeting of the House of Delegates. The Interim Committee recommends that the advisers appointed by the State Medical Society be invited to file an annual report containing observations and any recommendations they may have to offer.

Approval was given to the Student AMA recommendation on motion of Doctors Galasinski–Wegmann, carried.

(7) *The House of Delegates*

Councilors and officers must be aware of the confusion resulting from the fact that county medical societies have no regular pattern in the term of office assigned delegates and alternate delegates. As late as the middle of the month preceding the Annual Meeting, new delegates are selected. Under these circumstances there can be no orderly presentation of credentials or transmission of information important to each county medical society. On occasion within the past several years, an alternate delegate has served as alternate for a given delegate in the first session and for another delegate in the second session, and one or the other of the regular delegates has appeared for the third session. At the time of registration the staff is besieged by delegates who failed to receive credentials. For these reasons, the Interim Committee recommends to the Council that:

(a) A resolution be offered to the House of Delegates, requiring each county society to elect its delegates and alternates to serve a term of at least one calendar year, and in any event, that the term of office expire on December 31 of each year. This is consistent with the pattern of the AMA and means that no matter when a delegate is elected

to that office, he takes office on January 1 and serves until December 31 of the year in which his term expires.

(b) It be a standing rule of the House of Delegates that whoever is seated to represent a county medical society serves as delegate for the entire session.

(c) Credentials be distributed direct to delegates rather thas being routed through the county secretary as at present.

(d) Those registering for attendance at the House of Delegates other than as voting delegates be provided with special registration slips.

(e) The Credentials Committee be seated at the registration table to handle any problem that may arise.

There was considerable discussion of the various recommendations offered by the Interim Committee. There were several points on which the Council asked clarification and rewording, and recommendations were referred back to the Interim Committee, with the additional request of Chairman Arveson that Doctor Fons join the Interim Committee when the matter is next considered.

(8) *Legal Medical Institute in February 1954*

The Wisconsin Bar Association is arranging a legal medical institute in Milwaukee, and opportunity exists for the State Medical Society to act as co-sponsor. The program is essentially designed to help attorneys, and most of the program speakers will be physicians. Some of the subjects to be discussed include:

The Adequate Examination of an Injured Person

Relationship of Symptoms and Complaints to Actual Injuries

Traumatic Heart Injuries

Medicolegal Aspects of Plastic Surgery

Evaluation of Neuropsychiatric Disabilities

Amnesia and Aspects of Neuropsychiatric Disabilities Resulting from Traumatology of the Nervous System

Medical Preparation of a Personal Injury Suit

Intervertebral Disk and Back Injuries

The Interim Committee recommends that the State Medical Society participate as a co-sponsor, as the institute affords an excellent opportunity for the promotion of interprofessional relations and will probably be an annual event henceforth.

On motion of Doctors Dessloch–Heidner, carried, the Council approved sponsorship of the institute.

On further motion of Doctors Hill–Heidner, carried, it was recommended that the staff look into recording or publishing such papers presented at the institute as would be of interest to the general membership.

14. Approval of Minutes

Minutes of the October meetings of the Council were submitted in mimeographed form, and on motion of Doctors Zellmer–Kasten, carried, were approved as they are published in this issue of the Journal.

15. Wisconsin Welfare Council

Doctor Tenney pointed out that the Wisconsin Welfare Council is concerned with many problems having health implications, and that he felt it would be desirable to have the State Medical Society develop a closer liaison by carrying a membership in that group.

On motion of Doctors Dessloch–Hill, carried, Doctor Tenney's recommendation that the State Medical Society join the Wisconsin Welfare Council was approved.

16. Social Security Legislation

In response to the request of Doctor Kasten, Mr. Murphy, legal counsel, explained that efforts had been made during the past several years to bring self-employed physicians under the benefits of the Social Security Act, which has already been extended to cover most employed physicians. Mr. Murphy referred to an article on the subject in the November 7, 1953, issue of the Journal of the American Medical Association, entitled, "A Physician and An Economist Look at Old-Age and Survivor's Insurance." He pointed out that as now phrased, the Social Security Act benefits are highly advantageous to those in the more advanced age brackets, but are much less so to the younger men. This point had been emphasized in the article above referred to. He said that whether the Social Security funds would be adequate in the future would depend upon the benefits provided by Congress, the groups to which benefits were extended, and the rates charged against payrolls.

In response to other questions Mr. Murphy stated that Congress had taken no action during 1953 on the Jenkins–Keogh bill, under which physicians and other self-employed persons could deduct from their personal income tax returns the cost of certain types of provision for their old ages up to 10 per cent of their net incomes.

The Council received the above information, discussed it, but took no formal action with respect to it.

17. Adjournment

The Council adjourned its meeting at 12:00 noon, Sunday, November 22, 1953.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Copyright by the State Medical Society of Wisconsin, 1953
Volume 52 DECEMBER 1953 Number 12

COUNCIL ON SCIENTIFIC WORK

J. W. Gale—Madison
P. A. Midelfart—Eau Claire
S. A. Morton—Milwaukee
M. G. Rice—Stevens Point
L. G. Kindschi—Monroe
R. S. Baldwin (ex officio)—Marshfield
W. S. Middleton (ex officio)—Madison
J. S. Hirschboeck (ex officio)—Milwaukee

★

COLLABORATORS
THE COUNCIL

W. H. Costello—Beaver Dam
T. C. Hemmingsen—Racine
N. A. Hill—Madison
H. E. Kasten—Beloit
E. M. Dessloch—Prairie du Chien
A. H. Heidner—West Bend
A. J. McCarey—Green Bay
J. C. Fox—La Crosse
J. M. Bell—Marinette
R. E. Garrison—Wisconsin Rapids
R. G. Arveson—Frederic
Chairman
V. E. Ekblad—Superior
R. E. Galasinski—Milwaukee
E. L. Bernhart—Milwaukee
N. J. Wegmann—Milwaukee
W. T. Casper—Milwaukee
C. E. Zellmer—Antigo
J. C. Griffith—Milwaukee
Past-President
S. E. Gavin—Fond du Lac
Chairman Emeritus

EDITORIAL STAFF

R. S. BALDWIN, Marshfield—Medical Editor
J. M. SULLIVAN, Milwaukee—Editorial Director
MR. C. H. CROWNHART, Madison—Managing Editor
MISS AGNES PETERSON, Madison—Assistant Editor

★

EDITORIAL BOARD

D. W. Ovitt—Milwaukee
Frank Weeks—Ashland
Elwood Mason—Milwaukee
G. A. Cooper—Madison
V. S. Falk—Edgerton

★

ADVERTISING ADVISORY COMMITTEE

J. M. Sullivan—Milwaukee
R. S. Baldwin—Marshfield
W. T. Casper—Milwaukee
Mr. Roy T. Ragatz, Madison, Advertising Manager

Annual Subscription—$5.00 Single Copy—$ .50 Previous Years'— 1.00 Blue Book Issue—$2.00 a Copy

Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, 704 East Gorham Street, Madison 3

« « « EDITORIAL » » »

Programs for prevention of health problems have been found to pay dividends and are in extensive use in Wisconsin. Alertness of parents, teachers, and public health personnel in encouraging medical advice when there is *even slight evidence* of a problem means that many come under care when the maximum benefit can be gained.

Vision conservation is one phase of the Wisconsin Cooperative School Health Plan and emphasizes maintenance of favorable classroom conditions for protection of the eyes, detection of possible cases of defective vision among pupils by observation and screening, and cooperation with the plan for a follow-through to have vision corrected.

The following article points out the need for medical personnel to participate actively in programs of prevention and to commend parents and teachers for referral of suspected health problems.—CATHERINE K. CAMPBELL, *School Health Consultant, State Board of Health.*

Needless Referrals*

There are few ophthalmologists who have not been consulted by anxious parents with a child whose "vision," they have been told by the school, is defective. If their complaint is not this specific, it may be only that ". . . something is wrong with his eyes." Meanwhile, during the relating of the case history by anxious parents to the interested ophthalmologist, the child in question often stares calmly but perhaps interestedy around the office. When the child himself is asked a direct question, such as "How do your eyes bother you?" his answer will often be ". . . they don't." Somewhat nonplused by this answer, the physician nevertheless proceeds with a complete examination. At its conclusion, he will have found nothing—nothing, that is, but a perfectly normal pair of eyes in an apparently healthy child.

The manner in which the oculist chooses to tell the parents that there is nothing wrong with their child's eyes is particularly important. Consider for a moment who it was in the school that sent the note to the parents that "something is wrong" in the first place. It may have been the teacher or it may have been the school nurse, more likely the latter.

The basis for the note may have been mere observation of the child's behavior, the results of a visual acuity test, or the results of a series of more elaborate tests given on some visual screening device; more and more of the latter are appearing in use in the schools of today.

*Reprinted with permission from the *American Journal of Ophthalmology.*

The important thing is that someone had—or thought they had—a reason for suspecting an ocular defect. The manner in which we tell the parents that there is in fact no defect can affect their subsequent attitude toward not only the school and the school nurse but toward ourselves as oculists.

If the information is given in an abrupt, gruff, "I'm-too-busy-to-be-bothered-with-cases-where-nothing-is-wrong" manner, the reaction of a normal parent is to accept the ophthalmologist's word and then condemn the school nurse or teacher. After a day or two, the experience will often begin to rankle in the mind of the parent and frequently there is a turning against the ophthalmologist too—partly because a fee was charged when nothing was found to be wrong. This is, of course, illogical but is, nevertheless, the way that many persons react. If, at some future date, something is actually found wrong with the child's health during a school examination, a note sent home to the parents is likely to be ignored as "another false alarm."

How much better is the entire situation if the ophthalmologist informs the parents that nothing is wrong in a manner something like this: "You are fortunate in two ways. In the first place, a careful examination has revealed that there is nothing seriously wrong with your child's eyes and that whatever it was that made the school nurse or teacher suspicious must have been temporary. In the second place, you are fortunate to have your child in a school where some attention is paid to more than mere books. The school is apparently interested enough in your child to examine him and, at the time of the examination, his eyes didn't seem to be normal. There are children who are not fortunate enough to be watched that closely in school and occasionally they may have serious visual defects which remain undetected for years. Such a situation is certainly detrimental to a child and to his school life. Even though this examination has revealed nothing wrong with your child's eyes, you can be grateful and confident that you are not the only one interested in your child. His school is interested too."

The response of the average parents to this type of reasoning is almost invariably good. They no longer will leave the office feeling that this was a needless referral. Not only do they now know what, perhaps, before they had merely taken for granted, that their child's eyes are normal but there is a feeling of confidence and pride in the school system. And this is as it should be.

Ideally, of course, every child would have an ophthalmologic examination prior to beginning school. Practically this is not possible. The next best thing is for the schools to do the best they can with the equipment they have in attempting to detect physical defects and call them to the attention of the parents. Such a program will obviously result in a certain number of needless referrals. The manner in which the ophthalmologist handles the needless referral can make a big difference in the relationships between family and school. It is something worth thinking about.—RICHARD G. SCOBEE, M.D., *St. Louis, Missouri.*

Dates to Remember in 1954

The Council on Scientific Work announces five series of professional teaching programs for 1954 and tentative development of other meetings of special interest to members of the State Medical Society.

The dates and locations of the 1954 one-day teaching programs are as follows:

March 16, Monroe; March 17, Kenosha; March 18, Portage

April 13, Eau Claire; April 14, Stevens Point; April 15, Appleton (This series will be devoted solely to "Related Diseases of the Chest")

April 27, Platteville; April 28, Watertown; April 29, Manitowoc

May 25, Chippewa Falls; May 26, Ashland; May 27, Rhinelander

June 16, Racine; June 17, Elkhart Lake or Sheboygan; June 18, Menominee, Michigan (The Menominee meeting will be part of a two-day professional program sponsored by the Upper Peninsula Medical Association for MDs in that area)

* * *

Supplementary Teaching Programs:

A. *Cancer Clinics for MDs and Dentists:* The success of a recent series of meetings featuring oral cancer, aimed at dentists as well as physicians, held in hospitals at Eau Claire, Wausau, and Appleton, has prompted the Committee on Cancer to request approval for further development of such programs. The Council on Scientific Work has approved, and one-day meetings in selected areas will be developed during 1954. Watch for announcements!

B. *Special Meetings on Mental Deficiency:* During 1954, in cooperation with the Division on Mental Hygiene of the Department of Public Welfare, one-day clinics on mental deficiency will be held at Union Grove, Sparta, and Chippewa Falls. They will be aimed at general practitioners and designed to assist them in meeting problems as confronted in the care of patients.

C. *Conferences on Physicians and Schools:* During 1954 (and the spring of 1955) a series of one-day conferences on school health will be held at the various state colleges. While the Division on School Health will serve as main sponsor, cooperation will be extended through various health and educational agencies. Tentative dates and teaching sites: April 1954, Eau Claire; May 1954, Oshkosh; October 1954, Stevens Point; November 1954, La Crosse; April 1955, Whitewater; May 1955, Superior.

All Wisconsin physicians are urged to make note of these teaching programs and to participate in those scheduled within driving distance of their homes.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

Methantheline Bromide.—*Banthīne Bromide (Searle)*

β-Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. Searle & Co.
Powder Banthīne Bromide: 2 cc. ampuls. 50 mg.
Tablets Banthīne Bromide: 50 mg.

. . . . THE PRESIDENT'S PAGE . . . .

THE action of the House of Delegates in approving the Bricker Resolution has brought forth considerable comment from many sources. I'd like to take this opportunity to explain how I satisfied myself that we were right in doing so.

One of the frequently repeated arguments against our action is that since the Bricker Resolution is a political issue, it is not within the realm of things to be considered by organized medicine. Now, while it is perfectly true that the majority of "executive agreements," "treaties," "conventions," or whatever they may be called deal with military, financial, or reciprocal trade matters, there are some which potentially involve health matters and hence become of definite concern to organized medicine. The three most notable examples are these:

1. From the International Labor Office, Geneva, Switzerland, came the proposal for expansion of minimum social security standards which would have set compulsory medical standards and practices throughout the country irrespective of state laws or desires. To my mind this is socialized medicine imposed on us from without and would not be possible under the Bricker Resolution (unless the state legislatures assented).

2. Treaties with certain "most favored nations," as originally drafted, provided that nationals from these countries (Israel, Greece, and Denmark) could come to this country and carry on their trade or profession without restraint. This meant that physicians, for example, from any of these countries could come to Wisconsin and practice medicine without having to prove the adequacy of their education or their own competence. Fortunately, this provision was thrown out by the Senate, but as the matter now stands these nationals need not fulfill one requirement of our Medical Practice Act; namely, the taking out of at least first papers for citizenship. Since this abrogates one of our state laws in relation to public health, the question of treaties again moves out of the realm of the "purely political" and becomes a matter of concern to organized medicine.

3. Under the provisions of Article 55 of the United Nations Charter, each member nation agrees to promote the solutions of "health and related problems." Article 56 of the same charter pledges all members of the United Nations to take joint and separate action for the achievement of the pledge of Article 55. Competent legal authorities assert that this charter, which has the binding effect of a treaty, is sufficient to transfer all legislative authority in the health field from the states to the Congress. There is a growing body of legal and other opinion in this country which is already critical of the failure of the United States to implement Article 55 in accordance with the pledge given to the United Nations.

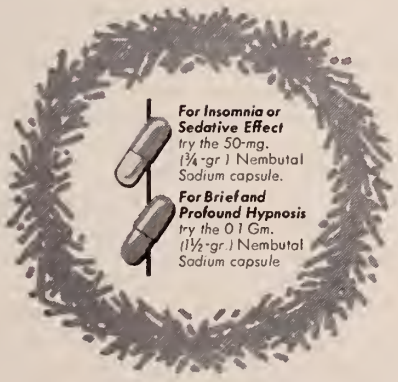
In the arguments pro and con as to the "hamstringing" effects of the Bricker Resolution on the President's power to make international agreements I find competent legal opinion very evenly divided. Some men whose opinion I respect highly say "yes"; others whom I respect just as highly say "no." Therefore my decisions had to be based on the other considerations I have mentioned above.

H. Kent Tenney M.D.

They'd decorate it all in an hour...

all the patients who represent the 44 uses for short-acting

NEMBUTAL®



● For every patient's need . . . in many dosage forms . . . *in more than 44 clinical conditions*, short-acting NEMBUTAL offers these advantages:

1. *Short-acting* NEMBUTAL (*Pentobarbital, Abbott*) *can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.*
2. *The dosage required is small—only about one-half that of many other barbiturates.*
3. *Hence, there's less drug to be inactivated, shorter duration of effect, wide margin of safety and little tendency toward morning-after hangover.*
4. *In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.*

Won't *you* remember—and compare—these advantages the next time, and every time, you write a barbiturate prescription?

Abbott

1-255A

The Wisconsin Press Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

Good Medical News

Good news continues to come from the medical front. . . .

The American Medical Association reports that the total number of students enrolled in approved medical schools has established a new record. . . . Several national organizations are devoting their energies and resources to fund raising to help relieve the heavy financial pressure that many schools are under in these inflated times.

The Chamber of Commerce of the United States made a survey of health insurance issued during 1952. . . . It finds that all types . . . showed an increase over 1951, generally by large percentages. . . .

Here is the answer to those who still argue that the only sure way to guarantee medical progress is through government-dominated medicine . . . at a cost of untold billions to the wage earners and businesses and taxpayers of this nation. No comparable country stands so high in the medical scale as ours —and free medicine has made that great achievement possible.—SHAWANO EVENING LEADER, Oct. 8, 1953.

At Taxpayers' Expense

A British woman, who is a member of parliament and parliamentary secretary to the ministry of health, plans a tour of this country. Her purpose is to talk to groups of all kinds in praise of England's national health service—the system under which the practice of medicine has been socialized in that country. . . .

What makes this visitor's tour interesting is its auspices. The trip is to be made under a Smith–Mundt grant. And the Smith–Mundt bill . . . was passed by Congress "to promote the better understanding of the United States among the peoples of the world and to strengthen international relations." The American taxpayers, of course, pay the bills for those who receive the grants. . . .

One wonders why the taxpayers should be assessed to subsidize projects, large or small, which, if successful, would eventually destroy America as we know it.—WAUKESHA DAILY FREEMAN, Nov. 4, 1953.

Low Pay Causes Public Loss

One of the most difficult jobs in state service is that of superintendent of the hospital for the criminal insane at Waupun. The state has been extremely fortunate in having in that job an exceptionally competent man, Dr. Jefferson Klepfer . . . who has now resigned to accept the superintendency of the state hospital at Richmond, Ind.

Among the several reasons for his resignation is the fact that he will receive higher pay in his new position, as well as a furnished house. . . . His salary here was $996 a month, including bonus. He lived in an apartment within the institution, for which he paid nominal rent. . . .

The state has, in recent years, revised its pay schedules for the rank and file of employees to a point where they compare favorably with those in private employment. It has raised some of the top salaries too, but in some instances not enough. For the top positions, it still has a considerable distance to go, both in salary ranges and in housing—where it is necessary that this be provided.—MILWAUKEE JOURNAL, Oct. 30, 1953.

Practical Nurses Needed

As our state's population increases, . . . the demand for more doctors, nurses, dietitians and technicians likewise increases. . . .

The ranks of the licensed trained practical nurses are expanding, but not nearly fast enough with the present needs or the likely needs of the near future. . . .

Because of this . . . many questionable "mail order" courses are being advertised; and hundreds of girls are wasting both time and money by enrolling in such "schools." Graduation from such courses does not qualify one for certification by the state as a practical nurse. . . .

The need for trained practical nurses is great, the work is challenging and the rewards are satisfying. Advice and guidance in selecting an approved school can be obtained from the Department of Nurses.—DE PERE JOURNAL–DEMOCRAT, Oct. 15, 1953.

Wisconsin's Medical Service

The State Medical Society's survey disclosing that services of physicians are now available to the people of Wisconsin at all hours of the day and night in every county is most heartening.

It's not so long ago that this comprehensive medical protection was not available, particularly in the more sparsely settled counties. . . . It is to the credit of the State Medical Society that a concerted effort has been made to remedy that situation.

Wisconsin's present emergency medical coverage is available either through the personal physician, some county medical society facility, or the nearest hospital. . . .—SUPERIOR EVENING TELEGRAM, Oct. 9, 1953.

535 North Dearborn Street, Chicago 10, Illinois

AMERICAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

DECEMBER 1953

Life's Busy for AMA President

"Home is where you hang your hat," and AMA President Edward J. McCormick has been hanging his most often in airplanes. During the first 10 months of 1953, Doctor McCormick has chalked up more than 35,000 miles in treks from his home in Toledo to New York City, Chicago, Denver, St. Louis, Salt Lake City, Milwaukee, Houston, and White Sulphur Springs, W.Va.—to mention only a few. His travel schedule for the rest of this year and the first few months of next reads like an airlines timetable.

Here are a few items listed on his schedule: Nov. 10–11, Association of Military Surgeons, Washington, D.C.; Nov. 12, American Society of Crippled Children and Adults, Chicago; Nov. 14, a function of the Michigan State Medical Association, Lansing; Nov. 19, speak at 10th annual conference of the Woman's Auxiliary in Chicago; Nov. 26, leave for AMA Clinical Session in St. Louis. On the docket for next year are speaking engagements in California in January; a commencement address at Toledo University in February; speaking engagements in March at AMA's Rural Health Conference in Dallas, the American Academy of General Practice meeting in Cleveland, and a scientific forum of the Omaha Centennial. In April he will speak to members of the Ohio State Medical Association and attend the Connecticut State Medical Association meeting. May, too, will be a busy month, with trips to Macon for the Medical Association of Georgia, Pinehurst for the Medical Society of North Carolina, Jackson for the Mississippi State Medical Association, Boston for the Massachusetts Medical Society, and Springfield, Mass., for the dedication of a municipal hospital.

And when Doctor McCormick has nothing else to do for AMA, he tends to his private surgery practice at St. Vincent's Hospital in Toledo and also does a job or two for the Elks, Lions, Boy Scouts, and other organizations in which he maintains active interest. So you can see that your president is doing his share toward promoting the positive side of American medicine.

AMEF '53 Goal in Sight

Nearing its 1953 goal of $1,000,000, the American Medical Education Foundation reports that donations so far this year have amounted to more than $950,000 from 15,151 contributors. Since December donations are not included, there is a good chance that the Foundation will reach its goal. The above figures already have established a new record. In 1951, the first year of operation, the Foundation raised $745,000 from 1,836 contributors and last year's receipts totaled $906,553 from 7,259 donors.

In reporting the new income figures, Dr. Louis H. Bauer, Foundation vice-president, pointed out that almost every state and local committee has stepped up activity in conjunction with the national direct mail campaign in an effort to raise additional funds for the country's medical schools. Types of campaigns have varied throughout the nation—in some states the committees are using a personal solicitation method, while other states have adopted voluntary assessments or increased society dues. Both Illinois and Utah, for example, have voted a $20 increase in state society dues. During the first 10 months of 1953, Illinois raised more than $179,000.

Dallas to Be Scene Of Rural Health Conference

Calling for all-out community teamwork, the ninth National Conference on Rural Health will stress the importance of individual participation in community affairs at the sessions to be held from March 4 to 6 in the Baker Hotel, Dallas. Sponsored by the AMA's Council on Rural Health, the Conference theme will be "Let's Put More 'U' In CommUNITY."

Leaders in the fields of medicine, agriculture, education, and public health will attend the formal sessions, which begin at 2:00 p.m. on Thursday, March 4, and continue through Saturday, March 6, winding up with a luncheon meeting at 1:00 p.m. Problems of nutrition and costs of medical and hospital care and methods of prepayment are the principal subjects to be discussed by outstanding rural health leaders. A major portion of the program will be devoted to success stories related by members of the audience.

In addition, a preconference session "for doctors only" will be held Thursday morning. Problems confronting physician-members of state rural health committees will be discussed, such as: (1) physician participation at the grass roots and (2) health insurance matters.

Newscopes

"First Prize" in the scientific exhibit section of the American Dental Association annual meeting in Cleveland was awarded to the AMA for its display, "You and Your Medical Care."—The AMA's Committee on Pesticides recently put out a new list of available publications. Titles of some of the publications are "Accidental Poisoning in Children," "Health Problems of Insecticide Vaporizing and Fumigating Devices," "Toxicology in Medical Curriculum," and "Use and Abuse of Generic Names for Pesticides."

Refresh...add zest to the hour

17–Ketosteroid

Determinations

Quantitative Gonadotrophin

Assays

Pregnancy Tests

Inquiries Invited

THE ENDOCRINE LABORATORIES

5001 West Belt Line Highway

MADISON 5, WISCONSIN

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

specialized service assures *"know-how"*

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 6-1021

COMMITTEE *Concentrates*

DIVISION OF MENTAL AND NERVOUS DISEASES OF COMMISSION ON STATE DEPARTMENTS
NOVEMBER 4
MILWAUKEE

MDs Present: E. D. Schwade (chairman), K. M. Keane, J. T. Petersik, Chester Wade, H. K. Tenney III.

The meeting was devoted to a determination of basic policies and relationships with the Division on Mental Hygiene of the Department of Public Welfare, as well as reactivation of subcommittee work on commitment laws, special problems of the disturbed child, and psychiatric training. Such subcommittees are to meet in the near future and to formulate full reports for evaluation and referral to the Commission on State Departments.

DIVISION OF MATERNAL AND CHILD WELFARE OF COMMISSION ON STATE DEPARTMENTS
NOVEMBER 11
MILWAUKEE

MDs Present: R. F. Purtell (chairman), Amy L. Hunter, A. H. Stahmer, J. D. Wilkinson, T. V. Geppert, F. G. Johnson, D. D. Willson, E. A. Birge, William Kreul (invited guest).

The major portion of the meeeting was devoted to formulation of plans for a series of pilot studies with selected hospitals during 1954, to cover fetal and neonatal deaths. Efforts will be made to relate the study to autopsies by pathologists, and possibly will be extended to other hospitals after 1955 . . . A survey on anesthesia practices in hospitals will be developed in cooperation with the Wisconsin Society of Anesthesiologists, and the Trained Nurse Anesthetists. In the near future key hospitals will be contacted to determine the best method of securing basic information sought, and the study will be launched in 1954 . . . Plans are being made for a series of one-day conferences with small groups of physicians and nurses to study procedures for proper handling of prematures in hospitals. Training programs will be conducted in Milwaukee and Madison if a survey of hospitals indicates a desire for this type of teaching program . . . A study is being made with the Department of Anesthesia of the University of Wisconsin Medical School to see if senior residents in anesthesia can be made available for short-term teaching programs in smaller hospitals, on the same basis as pediatric services were made available several years ago . . . During 1954 the Division will undertake to prepare a guide of suggested procedures and basic principles of approved practice in relation to maternal and child care which can be made available to hospital staffs and possible implementation by way of establishing hospital rules for local medical staffs.

COMMITTEE ON CANCER
NOVEMBER 19
MADISON

MDs Present: A. R. Curreri, P. B. Blanchard, R. B. Larsen, W. S. Bump, G. I. Uhrich, Lucille Radke, W. D. Stovall, Arthur Van Duser.

The Committee met as the Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society. It approved appropriations of $200 to support the 1954 Annual Meeting program and $400 for support of the postgraduate education program (circuit clinics); provided $500 for two nurse scholarships for a special nursing course in cancer, in New York; approved of paying full expenses for the field worker of the Wisconsin Division (a R. N.) for attendance at the same course; asked the Coordinating Committee on Cancer (representatives of the Committee on Cancer, the State Board of Health, and the two divisions of the American Cancer Society) to evaluate the present booklet on cancer supplied through the State Board of Health and the CA bulletin of the American Cancer Society to determine which should be sent to all MDs in the state; approved basic principles for the training of technicians in exfoliative cytology at the State Laboratory of Hygiene; and discussed an expansion of the clinics on oral cancer provided for MDs and dentists.

COUNCIL ON SCIENTIFIC WORK
NOVEMBER 21
MILWAUKEE

MDs Present: J. W. Gale (chairman) P. A. Midelfart, S. A. Morton, M. G. Rice, L. G. Kindschi.

The meeting was devoted to a review of the 1953 Annual Meeting and to preliminary formulation of scientific programs for 1954. Consideration was given to requests of the Committee on Cancer for extension of clinics on oral cancer (see above report of Committee on Cancer); to a request of the Division on Mental Hygiene of the Department of Public Welfare for a series of conferences on mental deficiencies and commitment procedures; and to a suggestion of a Milwaukee physician that an annual clinical conference be sponsored, alternating between Madison and Milwaukee (latter suggestion tabled because of frequency of meetings MDs now have to attend). Consideration was given to a request of Anesthesiologists that their meeting be scheduled in the afternoon (approved), and Section on Ophthalmology and Otolaryngology that their meeting continue the pattern of other years (approved) . . . Final determination of program content will be made in January, and members will be informed as to high lights during spring . . . Approval was given to the 1954 circuit teaching programs, and Dr. S. A. Morton was named to represent the Council on Scientific Work on the Coordinating Committee on Postgraduate Medical Education in the planning of scientific programs for 1955.

RELATED ACTIVITIES

The migrant worker problem is cropping up again, with the Wisconsin Welfare Council taking an active role in the study of various phases. A request has been made for formulation of a committee to outline basic policies in areas of health. Dr. D. E. Dorchester, chairman of the Council on Medical Service and Public Relations, will soon name such a special committee and get the work under way . . . The success of the Hearing Conservation Programs in Industry has prompted the Division on Hearing and Vision Defects to appoint a special subcommittee to study intensively this special problem and to come up with procedures and basic principles which can be presented to the Council for official approval and then offered to industries to assist them in the development of proper programs to meet the needs for participation in the Compensation Program. Members of this special committee are T. L. Tolan, Milwaukee, chairman; Meyer S. Fox, Milwaukee; Paul Whitaker, Milwaukee; Charles Taborsky, Madison; Linwood Gardner, Fond du Lac; and George Nadeau, Jr., Green Bay . . . The Study Committee of the Maternal Mortality Survey has to date reviewed some 50 maternal deaths in 1953, and has come up with some illuminating information which will be summarized in a report following the first full year of study . . . Tentative plans are being made for a series of regional conferences for physicians, school personnel, parents, and nurses during the late spring of 1955 and the following fall. Dr. E. H. Pawsat, chairman of the Division of School Health, is building the framework for the conferences, with representatives of the State Board of Health, the Department of Public Instruction, the Wisconsin Congress of Parents and Teachers, and other interested groups.

POSTGRADUATE COURSES SCHEDULED ON HEART AND LUNG DISEASE

To bring physicians up to date on recent advances in the diagnosis and treatment of heart and lung disease, two postgraduate courses have been scheduled during February and March by the Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools.

From February 15 to 19, the Second Regional Postgraduate Course on Diseases of the Chest will be held in New Orleans, Louisiana. The Seventh Annual Postgraduate Course on Diseases of the Chest will be held at Philadelphia's Bellevue–Stratford Hotel from March 15 to 19. Tuition for each course is $75.

For further information, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISC

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

This is typical of the newly instituted advertising series describing Blue Shield benefits.

These ads appear in all Wisconsin daily newspapers, and in about 65 weeklies.

"BLUE SHIELD paid our Doctor, even though Stephen didn't go to the Hospital"

says Mrs. Ben White, of Waupun

Mrs. White's story is one that many a mother could tell. Two-year-old Stephen was playing with the family dog on the living room floor. Suddenly, the dog turned and bit Stephen four or five times. You can imagine the terror in Mrs. White's heart. Of course, she rushed Stephen to the Doctor's office.

Stephen turned out to be seriously hurt—but he didn't need to go to the hospital. Twelve stitches were needed to close the cuts, and the Doctor ordered Stephen to take it easy. He was soon on the way to recovery.

Later, Mrs. White found out that BLUE SHIELD paid for Stephen's surgery in the doctor's office. She discovered that you don't need to be hospitalized to be eligible for BLUE SHIELD benefits. BLUE SHIELD provides benefits for surgical operations including treatments of cuts, wounds, and burns, no matter where the physician performs the treatment.

Beside *surgical benefits*, BLUE SHIELD will help you pay the costs of *medical care in a hospital*, X-Ray, and *anesthesia* performed by a doctor in connection with surgery or maternity, and *maternity care* if you have a group family contract. Better yet, BLUE SHIELD includes a provision under which most Doctors will accept BLUE SHIELD fees as *full payment* of the benefits available to eligible families.

YOUR FAMILY NEEDS BLUE SHIELD AND BLUE CROSS

BLUE CROSS, the companion plan to BLUE SHIELD, pays your hospital bills. BLUE CROSS is operated and sponsored by the hospitals, and BLUE SHIELD by the doctors. Both fine plans operate without profit, for your family's protection.

You can join BLUE SHIELD and BLUE CROSS easily and quickly, whether you work with a group of five or more people, with a smaller group, or are self-employed. One chance in three some member of your family will go to the hospital within the next year—better send in the coupon for information right now.

for protection that's priceless ... *Mail Now*

BLUE CROSS-BLUE SHIELD, 826 N. Plankinton Ave.
Milwaukee 3, Wisconsin

Name ..... Last Name ..... First Name ..... Initial

Address ..... Street No. ..... City ..... Zone ..... State

1. I am (check one) Employer ☐ Employee ☐
2. Our group has approximately ..... full-time employees
3. I am not employed in a group eligible for Blue Cross-Blue Shield, but would like information on Non-Group Blue Cross-Blue Shield Protection ☐

Firm Name .....

Address .....

If you are in a supervisory position, what is your title? 15

BLUE CROSS-BLUE SHIELD

Associated Hospital Service, Inc. — The Hospitals' Plan
Wisconsin Physicians Service — The Doctors' Plan

826 N. Plankinton Avenue • BRoadway 6-4600
Milwaukee 3, Wisconsin

For information or Advice

Write • 704 E. GORHAM ST., MADISON, WIS. *Phone* • 6-3101 MADISON, WIS.

Society Proceedings

Brown–Kewaunee–Door

A regular meeting of the Brown–Kewaunee–Door Counties Medical Society was held at the Elks Club in Green Bay on October 8. Delegates to the State Medical Society Annual Meeting presented their reports.

Meeting again at the Elks Club on November 12, members of the society heard *Dr. Christopher R. Dix*, plastic surgeon from Milwaukee, discuss "Traumatic Injuries of the Face." A seven o'clock dinner preceded the meeting.

Dodge

Members of the Dodge County Medical Society named *Dr. Leonard W. Schrank*, Waupun, president of their group at a recent meeting at the Lutheran Hospital in Beaver Dam. *Dr. H. G. Bayley* was elected vice-president, and *Dr. R. F. Boock* is to be the secretary-treasurer. Both of these physicians are from Beaver Dam.

Dr. Joseph Brown, Cambria, who has recently returned from a tour of duty in Korea, spoke about the medical aspects of the war and showed colored slides to illustrate his talk. Reports from the Annual Meeting of the State Medical Society were given by *Dr. W. H. Costello*, Beaver Dam, and Doctor Schrank.

Douglas

New officers elected at the Douglas County Medical Society meeting held on November 4 at the Hotel Superior are:

President—*Dr. Charles J. Picard*
Vice President—*Dr. F. W. Reibold*
Secretary—*Dr. R. P. Fruehauf*
Delegate—*Dr. Charles W. Giesen*
Alternate Delegate—*Dr. F. W. Reibold*

All of these physicians are from Superior.

"Care of the Premature Infant" was the topic presented by the guest speaker, Dr. Robert O. Bergan of Duluth, Minn. Among the items of business discussed was the question of financing the state hospital for the care of the tuberculous insane. It was decided to support Bill 704, S., now before the Assembly, which will help correct the financial problem of supporting the institution which exists under present laws.

Fond du Lac

Dr. Ovid O. Meyer, professor of medicine at the University of Wisconsin Medical School, spoke at the October 22 dinner meeting of the Fond du Lac County Medical Society held at the Elks Club. His subject was "Recent Advances in Therapy." During the business session, *Dr. H. J. Kief*, delegate to the Annual Meeting of the State Medical Society, presented his report, and members discussed actions taken by the House of Delegates.

On November 19, members of the society heard *Dr. Clifford H. Kalb*, Milwaukee specialist in the diseases of allergy, discuss "Asthmatic Problems and the Family Physician." This meeting was also held at the Fond du Lac Elks Club.

Green Lake–Waushara

"Importance of the Sulfa Drugs in Treating Pediatric Patients" was the title of the paper presented by *Dr. C. R. Peterson* at the Green Lake–Waushara Counties Medical Society meeting at the Markesan Medical Center on October 22. Doctor Peterson is associated with the Sharpe Clinic in Fond du Lac.

Members taking part in the discussion were *Drs. Roy Hong*, Wild Rose; *A. C. Theiler*, Princeton; and *A. J. Wiesender*, Berlin.

Kenosha

Forty-two members of the Kenosha County Medical Society heard Dr. Carl Davis, surgeon at the Presbyterian Hospital, Chicago, discuss "Portal Hypertension" at their meeting at the Elks Club on November 5. Doctor Davis supplemented his talk with a movie showing the operation, porta-vena-caval shunt for cirrhosis of the liver.

Oconto

Dr. Forrest E. Zantow, Oconto, was elected president of the Oconto County Medical Society at its October 20 meeting, held at the Alamo in Stiles. He succeeds *Dr. D. M. Bailey* of Gillett. *Dr. G. R. Sandgren*, Suring, will continue as secretary-treasurer and was also named president-elect of the society. After the business meeting, members saw three films—"Surgical Repair of Sliding Hernia," "Parkinson's Disease," and "Clinical Uses of Varidase."

Pierce–St. Croix

Guest speaker at the September 29 meeting of the Pierce–St. Croix Counties Medical Society at the Limberg Clinic, Glenwood City, was *Dr. F. E. Mohs*, associate professor of chemosurgery at the University of Wisconsin. Doctor Mohs discussed his new method of treating skin cancers and presented to the group several patients who have been successfully treated by this method.

Dr. H. M. Frykman, proctologist from Minneapolis, spoke at the meeting of the society held on Octo-

ber 20 in Hudson. He discussed the latest developments in the treatment of the rectum, with special emphasis on the dangers of injection therapy for hemorrhoids, and stressed the need for early diagnosis of cancer of the rectum. *Dr. O. H. Epley* of New Richmond, who was the delegate to the Annual Meeting, presented a report on the activities of the House of Delegates in their continuing efforts to maintain adequate standards of medical practice in Wisconsin.

Section on Neurology and Psychiatry

At the meeting of the Section on Neurology and Psychiatry of the State Medical Society held on October 6 at Milwaukee's Hotel Schroeder, the following resolution was passed by a unanimous vote:

BE IT HEREBY RESOLVED, That the Section on Neurology and Psychiatry of the State Medical Society of Wisconsin go on record as being favorably impressed by the manner in which the State Medical Society and its officers so efficiently conducted the various meetings of committees and subcommittees which were attended by various members of the Section on Neurology and Psychiatry during the past year.

AND BE IT FURTHER RESOLVED, That the Secretary of the Section be instructed to inform the Secretary of the State Medical Society of the commendable efforts of the Society in this regard.

American Academy of General Practice Appleton Chapter

Dr. C. W. Crumpton of the University of Wisconsin Medical School addressed a dinner meeting of the Appleton Chapter of the American Academy of General Practice held at the Elks Club on October 22. "New Treatment of Hypertension" was Doctor Crumpton's topic.

Three other meetings of the group are scheduled for this year, the next to be held in either Manitowoc or Sheboygan.

Wisconsin Academy of General Practice

The Wisconsin Academy of General Practice held its annual meeting from November 16 through 18 at the Hotel Schroeder in Milwaukee. A business session occupied the opening day of the meeting, and scientific sessions were held on the last two days.

Wisconsin physicians who took part in the meeting, and the titles of their speeches, were as follows:

H. Kent Tenney, Madison—"Preventive Psychiatry—A Medical Responsibility"

William H. Frackelton, Milwaukee—"Management of Facial Injuries"

Robert F. Purtell, Milwaukee—"Control of Pain in Childbirth"

Axel Trangsrud, Milwaukee—"Management of Urinary Tract Infections"

In very special cases

A very superior Brandy

Specify 84 PROOF

★ ★ ★

HENNESSY

THE WORLD'S PREFERRED
COGNAC BRANDY

For a beautifully illustrated book on the story of Hennessy, write—

Schieffelin & Co., Dept. HT, 30 Cooper Square, N.Y. 54

Cook County Graduate School of Medicine

POSTGRADUATE COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 18, February 1, February 15, 1954

Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 1, 1954

Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 15, 1954

General Surgery, Two Weeks, starting April 26, 1954

Surgery of Colon & Rectum, One Week starting March 1, 1954

Fractures & Traumatic Surgery, Two Weeks, starting March 1, 1954

GYNECOLOGY—Intensive Course, Two Weeks, starting February 15, 1954

Vaginal Approach to Pelvic Surgery, One Week, starting March 1, 1954

OBSTETRICS—Intensive Course, Two Weeks, starting March 1, 1954

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting March 15, 1954

Gastroscopy, Two Weeks, starting March 8, 1954

Two-week Intensive Course starting May 3, 1954

DIAGNOSTIC X-RAY—Clinical Course every week by appointment

CYSTOSCOPY—Ten day practical course starting every two weeks

UROLOGY—Two-Week Intensive Course starting April 19, 1954

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Lloyd F. Jenk, Milwaukee—"Clinical Significance of Common Neurological Findings"
Tibor J. Greenwalt, Milwaukee—"Management of Hemolytic Disease of the Newborn"
John D. Owen, Milwaukee—"Diagnosis and Treatment of Hyperestrogenemia"
William B. Hildebrand, Menasha, President-elect, AAGP—"The AAGP: A Progress Report"
Robin N. Allin, Madison—"Iatrogenic Heart Disease"
Joseph V. Herzog, Milwaukee—"Proctology in General Practice"
Merlyn C. F. Lindert, Milwaukee—"Preoperative Hepatic Evaluation"

A Milwaukee physician, *Dr. Joseph S. Devitt*, served as chairman of the three-day session. *Drs. C. G. Reznichek*, Madison; *John A. Enright*, Milwaukee; *Edgar M. End*, Wauwatosa; and *David N. Goldstein*, Kenosha, acted as moderators of the various sessions. The address of welcome was given by *Dr. John S. Hirschboeck*, dean of the Marquette University School of Medicine.

Physicians from Chicago, Cleveland, Rochester, Minn., and Indianapolis also took part in the program. Annual dinner speaker on November 18 was Calvin D. Johnson, former Republican Congressman from Illinois.

Affiliated with the American Academy of General Practice, the Wisconsin Academy is the sixth largest of such associate groups, having an enrollment of about 600 members. The national group numbers approximately 16,000.

News Items and Personals

Delavan Clinic Adds Doctor

Drs. T. L. Jacobson, N. F. Crowe, and *R. S. Galgano* of the Delavan Clinic have been joined by Dr. Glenn A. Smiley, who will serve as general physician and surgeon. A graduate of Marquette University School of Medicine, Doctor Smiley served a year's internship at St. Mary's Hospital in Milwaukee and also completed a one-year residency in general practice at St. Michael's Hospital there. During World War II, Doctor Smiley spent almost a year with the Army Air Force in the European theater.

Doctor Curtis Renews Practice in Elroy

Returning after an absence of 23 years, Dr. William E. Curtis has opened a new office in Elroy, where he practiced from 1927 to 1930. Since 1930 he has been practicing in Milwaukee and in Illinois.

His son, *Dr. William C. Curtis*, a Milwaukee physician, plans to work in the Elroy office with his father on Saturdays and Sundays. A son-in-law now completing medical school may also join the elder Doctor Curtis later.

Doctor Gosin Joins Clinic Staff

Dr. Robert Gosin has joined the staff of the Gosin Clinic in Green Bay, where he will engage in the general practice of medicine. He received his medical degree from Marquette University School of Medicine in 1952, interning at St. Mary's Hospital in Milwaukee. While at Marquette, he served for one year as an extern at Evangelical Deaconess Hospital.

ACS Honors 16 Wisconsin Physicians

Fellowship in the American College of Surgeons was awarded to 16 Wisconsin doctors on October 9, the closing day of the annual meeting of the College in Chicago. The group receiving the award included *Dr. H. R. Sharpe, Jr.*, Fond du Lac; *Dr. E. E. Eckstam*, Monroe; *Dr. R. T. Thompson*, Superior; *Drs. E. A. Bachhuber, J. D. Conway, S. G. Higgins, A. J. Krygier, L. S. Hobbins*, and *N. J. Wegmann*, all of Milwaukee; *Drs. W. B. Hobbins, J. J. Mueller, E. E. Skroch*, and *R. C. Wixon*, all of Madison; and *Drs. W. H. Bennett, Elizabeth A. Steffen*, and *L. R. Grinney*, Racine.

Doctor Low Has New Associate

Dr. Niels L. Low, Racine, has announced that he has been joined in his practice by Dr. Alfred E. Graf, a pediatrician.

Doctor Graf received his degree in 1947 from Tufts College Medical School in Boston and interned at Memorial Hospital in Worchester, Mass. His postgraduate work includes a twelve-month residency in pathology at St. Elizabeth's Hospital, Brighton, Mass., and a four-month residency in pediatrics at Milwaukee County General Hospital. From July 1951 to July 1953 he served with the armed forces.

Eleva Clinic Opens

September 5 was the opening date of the new Eleva Clinic, plans for which were started by an organization of Eleva businessmen, the Eleva Commercial Club. Equipped with offices for two doctors,

two examining rooms, a laboratory, and an x-ray room, the clinic is staffed by Eleva's new doctor, Dr. Rodney Wichmann, and Doctor Wichmann's wife, who will serve as assistant and receptionist.

A native of Eleva, Doctor Wichmann graduated from the University of Wisconsin Medical School in 1952 and completed his internship at Millar Hospital in St. Paul, Minn., in July 1953.

"Doctor Rose Day" Held in Lena

Residents of Lena and the surrounding community gathered at the Lena High School gymnasium on November 8 to pay tribute to *Dr. J. F. Rose*, who has given 46 years of medical service to the area. Doctor Rose settled in Lena on August 23, 1907.

Among those at the reception were the first child and the first pair of twins delivered by Doctor Rose and also a family of three generations that has been served by the physician.

Dr. S. L. Hadden Becomes Member of ICS

On September 17, *Dr. S. L. Hadden*, Wild Rose, was elected to membership in the International College of Surgeons at a meeting of the organization in New York City.

Doctor Hadden is chief of staff at the Wild Rose Hospital, which he built in 1940 and has been operating since it opened in February 1941.

Barron Physician Honored

Dr. G. A. Fostvedt, Barron, was recently elected to membership in the New York Academy of Science. Honorary appointments in the Academy are given to physicians who have made original contributions toward the understanding of medical problems through scientific publications. Scientific problems about which Doctor Fostvedt has written include detection of poisons, relation of hormones and enzymes in skin pigmentation, chemical peritonitis, and hay silage gas poisoning.

Adams Has New Physician

Dr. J. J. Brenner has come from Lansing, Mich., to set up a practice in Adams. A 1950 graduate of Marquette University School of Medicine, Doctor Brenner served his internship at St. Lawrence Hospital in Lansing and spent the past two years in practice in that city.

T. P. Froehlke Enters Military Service

Dr. T. P. Froehlke, practicing physician in Hillsboro since 1951, has been called into military service and is stationed at the Air Force Base School of Aviation Medicine, Randolph Air Force Base, San Antonio, Texas. In February he expects to be permanently assigned to Atterbury Air Force Base in Indiana.

SHOREWOOD
HOSPITAL • SANITARIUM
2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: WOodruff 4-0900

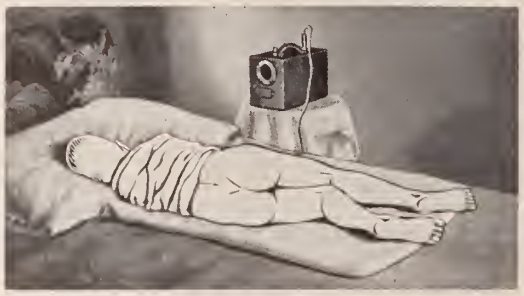
For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899



NOW . . . An effective treatment for

ENURESIS

The S. & L. Enuresis Alarm rings a bell and awakens sleeping patient immediately after urination begins—before all urine can be voided. Usually breaks the enuresis habit in three to four weeks. Does not shock patient.

HIGHLY EFFECTIVE—In over 2 years of use under medical supervision, 91% of all cases treated were arrested. All had been previously treated, unsuccessfully, by conventional methods.

Available for patient rental on your prescription. Write for details.

S. & L. SIGNAL COMPANY

525 Holly Avenue, Madison 5, Wisconsin

To Serve Your
Complete Prosthetic & Orthopedic
Appliance Needs

HOUSE OF BIDWELL, INC.

MILWAUKEE, WIS.
535 N. 27th St.
R. G. Bidwell
Phone: Di 4–1950

MADISON, WIS.
520 S. Park St.
R. N. Bidwell
Phone: 6–5303

"Orthopedic Appliances"

of every description
have been our specialty for 32 years.

Trained Mechanics and Fitters only

Trusses, Elastic Stockings, Abdominal Belts.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells St.
Tel. Daly 3021 Milwaukee, Wis.

Before coming to Hillsboro, Doctor Froehlke practiced in New Lisbon from July 1950 to May 1951. He plans to return to Hillsboro after his two-year tour of duty with the armed forces.

THIRD AND TWELFTH DISTRICTS NEWS

Two Physicians Join Munn–Koch Clinic

Dr. John J. Tordoff, surgeon, and Dr. Thomas W. Dorman, general practitioner, are new members of the Munn–Koch Clinic staff in Janesville.

A veteran of World War II, Doctor Tordoff has been at Veterans Administration Hospital, Wood, for the last five years. He graduated from Marquette University School of Medicine in 1941 and interned at St. Mary's Hospital, Milwaukee. Before going into service, he practiced briefly in Burlington and Tomah.

Doctor Dorman has already spent one year in Janesville as an intern at Mercy Hospital. He received his medical degree from Loyola University School of Medicine, Chicago, in 1952.

Doctor Bear Speaks in California

"Tibial Fractures" was the title of the paper presented by *Dr. Nathan E. Bear*, Monroe, at the convention of the American Fracture Association held in Riverside, Calif., in early October. Dr. William Johnson of the Galesburg (Ill.) Clinic appeared on the program with Doctor Bear.

Janesville Physician Certified in Ophthalmology

Dr. John F. Pember, Janesville, has recently been certified by the American Board of Ophthalmology. Doctor Pember received his medical degree from Northwestern University Medical School in 1946. After completing his internship at Cook County Hospital in Chicago, he served with the armed forces. At present he is in practice with his father, *Dr. Aubrey H. Pember*.

Doctor Middleton Honored

Dr. William S. Middleton, dean of the University of Wisconsin Medical School, was the honored guest at the Midwest regional meeting of the American College of Physicians, of which he is a former president. Among the physicians participating in the scientific portion of the meeting were Drs. Gerald C. Mueller, *Thomas H. Lorenz*, and *Marc J. Musser*, all of Madison. "Sex Hormones in Experimental Cancer" was discussed by Doctor Mueller, "Life Stress, Emotions, and Spontaneous Pneumothorax" by Doctors Lorenz and Musser.

At the 64th annual meeting of the Association of American Medical Colleges Doctor Middleton was elected vice-president to serve through 1954. The meeting, held in Atlantic City, N. J., in October, was attended by more than 400 medical educators.

Madison Physician Certified in Ophthalmology

Dr. G. E. Oosterhous was made a diplomate of the American Board of Ophthalmology on October 15. Beginning his training in ophthalmology in September 1948 with an apprenticeship of seven months at the Davis and Neff Clinic in Madison, Doctor Oosterhous joined the resident staff of the eye service at Wisconsin General Hospital in April 1949 and completed his residency there in 1951. At that time he opened the office for the practice of ophthalmology which he now maintains in Madison.

Jackson Clinic Adds Pediatrician

E. M. PARKIN

Dr. Edward M. Parkin has joined the staff of the Jackson Clinic and Methodist Hospital, where he is associated with *Dr. Margaret Prouty* in the department of pediatrics.

A graduate of the University of Rochester School of Medicine in Rochester, N. Y., Dr. Parkin served his internship and a two-year residency in pediatrics at City Hospital, St. Louis, Mo. After three-and-a-half years of service with the Army Medical Corps in the South Pacific, he went to La Crosse, where he has been practicing for the last five years.

Doctor Meiskothen Opens Office

Dr. W. E. Meiskothen has opened an office for the general practice of medicine in Madison. A veteran of three years of army service, he has been associated with the Veterans Administration Hospital in Madison for the last few months.

Doctor Meiskothen was graduated from Loyola University School of Medicine in 1952. He served his internship at Milwaukee County Hospital.

Doctor Trautmann Speaks to PTA

"Is Your Child Well Fed?" was the subject chosen by *Dr. Henry Trautmann* of Madison to present to the Prairie du Sac PTA meeting on November 9. The meeting was held in the high school auditorium.

Since his retirement from active practice a few years ago, Doctor Trautmann has become particularly interested in the field of nutrition and is widely known for his work in the field. He practiced in Brooklyn and Jackson Heights, N. Y., for almost 30 years before coming to Madison.

PORTABLE OXYGEN . . .

constantly at your service

You now can have oxygen available whenever you need it for medical emergencies in your office or on calls. A portable "Q" cylinder of "Linde" Oxygen U.S.P. plus a clinical regulator and mask will help you cope with anoxia without delay.

A "Q" cylinder contains enough oxygen for about five hours use. Keep a "Q" and a regulator in your office; take it along on calls for emergency use.

available from any of these distributors of

Linde OXYGEN U.S.P.

Bentley Sales Co.,
645 S. 28th St.,
Milwaukee, Wis.

Green Bay Welding Supply,
Cedar & N. Quincy Sts.,
Green Bay, Wis.

Northern Welding and Supply Co.,
736 Jefferson St.,
Wausau, Wis.

Red Arrow Sales Corp.,
650 E. Main St.,
Madison 3, Wis.

Sommerfeld Welder's Supply Co., Inc.,
North Jackson Drive,
Oshkosh, Wis.

Standard Service & Supply Co.,
Box 668,
Iron Mountain, Mich.

LINDE OXYGEN USP • OXYGEN THERAPY REGULATORS
LITER FLOW ADAPTORS • OXYGEN THERAPY ADMINISTERING EQUIPMENT

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

Doctor Fritz Kant Speaks in Wausau

FRITZ KANT

"Emotional Disturbances of Middle Life" was the topic discussed by *Dr. Fritz Kant*, professor of neuropsychiatry at the University of Wisconsin, in the fourth of a series of lectures on mental hygiene sponsored by the University Extension Center in Wausau. The lecture was given in the Senior High School library on October 15.

Mental preparation for acceptance of competition from younger men, for giving up active jobs, and for accepting demotion to jobs with less responsibility was Doctor Kant's suggested solution for avoiding the emotional disturbances that often occur between ages 45 and 65.

A graduate of the University of Tübingen, Germany, Doctor Kant was formerly director of the psychiatric outpatient department of the Kraepelin Clinic of Psychiatry in Munich and has also been associated with the psychopathic hospital at Harvard University.

Doctor Tenney is Speaker at "Easter Seal Agency" Meeting

Dr. H. Kent Tenney, newly elected president of the State Medical Society, spoke at the opening session of the 28th annual convention of the Wisconsin Association for the Disabled at the Plankinton House in Milwaukee on October 22 and 23. Choosing for his title "We Set the Pattern Early," Doctor Tenney stressed the importance of recognition by professional welfare workers and also by the general public that physically handicapped children are just the same emotionally as normal children are. Whether handicapped or normal, all children, according to Doctor Tenney, need the same three things—the feeling of security that stems from the knowledge that they are wanted for themselves alone, a feeling of success and achievement, and a feeling of self-confidence.

Dr. Clinton N. Woolsey, neurophysiology and research specialist at the University of Wisconsin, and *Dr. Raymond C. Waisman*, Milwaukee, also took part in the convention program. On October 23, the second day of the meeting, Doctor Woolsey spoke to the convention on "The Importance of Research," and Doctor Waisman described the work of the Cerebral Palsy Clinic of the Medical Society of Milwaukee County.

BARR X-RAY CO.

Exclusive Wisconsin Distributors

for

F. MATTERN MFG. CO.

Quality X-Ray Equipment

1924 W. Clybourn St. Milwaukee 3, Wisconsin

Distributors to the profession

of fine

Injectable Vitamins and Endocrines

Interstate Pharmacal Company

P. O. Box 252 Beloit, Wis.

MAIL ORDERS SHIPPED IMMEDIATELY

THE MARY POGUE SCHOOL

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

Catalogue on request.

G. H. MARQUARDT, M. D.
Medical Director

BARCLAY J. MACGREGOR
Registrar

32 Geneva Road, Wheaton, Ill. (Near Chicago)

Milwaukee Physician Elected Officer of New Foundation

T. L. SQUIER

Dr. Theodore L. Squier of Milwaukee has been elected treasurer of the American Foundation for Allergic Diseases, a newly established organization under the joint sponsorship of the American Academy of Allergy and the American College of Allergists.

The Foundation has the following aims: to promote through public education an accurate understanding of the problem of the allergic diseases; to inform and educate the medical profession in the problems of allergy; to cooperate with medical institutions, hospitals, and other organizations for the development of facilities for the treatment and prevention of allergic diseases; and to provide facilities for research, including fellowships and residencies.

Dane

The Dane County Medical Society installed new officers at its meeting on October 13. Chartered in September 1903, the society was observing its 50th anniversary at this meeting.

Dr. Samuel L. Chase was installed as the new president and *Dr. George C. Hank* as president-elect. *Dr. S. C. Rogers* was re-elected vice-president and *Dr. G. E. Oosterhous* will continue as secretary-treasurer. All of the officers are from Madison.

Rock

Dr. Milton D. Davis, Milton, was elected president of the Rock County Medical Society at its regular meeting on October 27 at the Hotel Hilton in Beloit. Other officers named by the society were *Dr. C. M. Carney*, Beloit, vice-president; *Dr. Herbert M. Snodgrass*, Janesville, secretary-treasurer; *Dr. Richard A. Thayer*, Beloit, delegate; and *Dr. Richard W. Farnsworth*, Janesville, alternate delegate.

Speaker at the meeting was Dr. Chester C. Guy, Chicago, who discussed "Problems of Hernia Repair."

Sauk

Dr. John B. Wear, Madison, was the guest speaker at the regular meeting of the Sauk County Medical Society held on October 13 at the Warren Hotel, Baraboo. He discussed "Uremia in Acute Renal Failure."

Also taking part in the program were *Dr. John D. Silbar*, senior resident in urology at Wisconsin General Hospital, Madison, and *Dr. John J. Rouse*, Reedsburg. Doctor Rouse gave the delegate's report of the Annual Meeting.

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director

Frank W. Mackoy, M. D. — John E. Leach, M. D.

J. Frampton Wyman, M. D. — Lloyd F. Jenk, M. D.

Hubert H. Blanchard, M. D. — James F. McDonald, Jr., M. D.

Wendell T. Wingett, M. D.

Hearing Panel Features Doctor Tolan

Dr. T. L. Tolan, Milwaukee, was one of three doctors participating in the program of the industrial noise control and hearing conservation clinic held in Racine on October 14. Doctor Tolan is president of the American Hearing Society.

Doctor Tolan's associates on the panel were Dr. D. E. Wheeler of Los Angeles, a member of the American Academy of Ophthalmology and Otolaryngology, and Dr. Aram Glorig, Walter Reed Hospital, Washington, D. C.

Milwaukee

Highlighting the first fall meeting of the Medical Society of Milwaukee County was a speech by Dr. G. L. Carroll of St. Louis on the problems resulting from the widespread use of antibiotics in the treatment of urinary tract infections. The meeting was held at the Milwaukee Athletic Club.

A widely known urologist, Doctor Carroll is associate professor of clinical urology at St. Louis University and associate chief of staff at St. John's Hospital in St. Louis.

Milwaukee Academy of Medicine

Dr. I. S. Ravdin, professor of surgery at the University of Pennsylvania School of Medicine, was guest speaker at the November 17 meeting of the Milwaukee Academy of Medicine. Doctor Ravdin discussed "Some Important Adjuncts to Surgical Therapeusis."

Milwaukee Neuro-Psychiatric Society

Meeting at the University Club of Milwaukee on November 18, members of the Milwaukee Neuro-Psychiatric Society heard a lecture entitled "Some Basic Problems in Psychosomatic Medicine." Dr. Roy R. Grinker, director of the Institute for Psychosomatic and Psychiatric Research and Training at Michael Reese Hospital in Chicago, was the speaker.

Members of neuropsychiatric sections of the Veterans Administration from Milwaukee and Wood, as well as members of the Milwaukee Academy of Medicine, were guests of the society at this meeting.

Milwaukee Oto-Ophthalmic Society

"Radiation Therapy of EENT Lesions" was the title of *Dr. Maurice Greenberg's* address given at a meeting of the Milwaukee Oto-Ophthalmic Society at Milwaukee County General Hospital on November 24. County staff members also presented clinical cases.

ACCIDENT • HOSPITAL • SICKNESS

INSURANCE

For Physicians, Surgeons, Dentists Exclusively

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL CLAIMS GO TO

$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$19,500,000.00 PAID FOR CLAIMS

51 years under the same management

400 First National Bank Building **Omaha 2, Nebraska**

$200,000.00 deposited with State of Nebraska for protection of our members

When writing advertisers please mention the Journal.

Multiple Sclerosis Society of Milwaukee

Giving members of the Multiple Sclerosis Society of Milwaukee "A Positive Program for the Multiple Sclerotic," *Dr. E. P. Roemer* of Madison was the featured speaker at the November 6 meeting of the society. Doctor Roemer, a native of Milwaukee, is director of the Wisconsin Multiple Sclerosis Clinic in Madison.

MARRIAGES

Dr. John F. Brown, Madison, to Miss Dori Grossen, Mt. Horeb, October 10.

Dr. Robert P. Lyons, Madison, to Miss Colette Ann McBride, Milton, October 10.

SOCIETY RECORDS

New Members

Anne E. Roethke, 8740–A West Mitchell Street, Milwaukee.

P. W. Murphy, Bloomer.

G. A. Berglund, 110 East Main Street, Madison.

R. B. Foe, 108 Craig Avenue, Madison.

L. G. Kilpatrick, 806 Clymer Place, Madison.

J. M. Lee, 1300 University Avenue, Madison.

Wayne Round, 1300 University Avenue, Madison.

J. E. Thompson, Hess Clinic, Mauston.

E. S. Hartlaub, 60 South Main Street, Janesville.

R. S. Overton, 58 South Main Street, Janesville.

H. H. Larson, 301 North Main, Rice Lake.

D. J. Welter, Shell Lake.

W. H. Houlton, Cumberland.

G. J. Derus, 4601 Monona Drive, Madison.

E. R. Liebl, 113 North Carroll, Madison.

D. A. Peterson, 224 West Washington Avenue, Madison.

W. P. Crowley, Jr., 2112 Jefferson Street, Madison.

Changes in Address

P. E. Podruch,* Wausau, to Medical Company, 7th Infantry Regiment, Third Division, A.P.O. 468, % Postmaster, San Francisco, California.

K. J. Siegrist, Wood, to P. O. Box 783, Appleton.

J. E. Koepsell,* Fort Sheridan, Illinois, to 606 North Hart Boulevard, Harvard, Illinois.

W. E. Scheunemann, Thiensville, to 128 North Main Street, West Bend.

T. P. Froehlke,* Hillsboro, to School of Aviation Medicine, Randolph Air Force Base, Texas.

C. E. Lindemann,* Fort Riley, Kansas, to 4924 Upton Avenue, South, Minneapolis, Minnesota.

Eugenia S. Cameron, Madison, to Footehill Road, Northford, Connecticut.

Armin Steckler, West Allis, to 4823 West North, Milwaukee.

W. L. Coon, Glendale, California, to 1031 South Broadway, Los Angeles, California.

---

* Military Service.

RADIUM and RADIUM D+E

(Including Radium Applicators)

FOR ALL MEDICAL PURPOSES

Est. 1919

Quincy X-Ray and Radium Laboratories

(Owned and Directed by a Physician–Radiologist)

HAROLD SWANBERG, B. S., M. D., Director

W. C. U. Building Quincy, Illinois

DOERFLINGER ARTIFICIAL LIMB CO.

Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
TRUSSES—SUPPORTERS
ELASTIC STOCKINGS
INVALID CHAIRS—CRUTCHES

Superior Custom Work
Woman Attendant for Women

2525 W. Fond du Lac Ave. Hopkins 2–2525
MILWAUKEE, WISCONSIN

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL

(The Pioneer Post-Graduate Medical Institution in America, Organized in 1881)

For the GENERAL PRACTITIONER

Intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

EYE, EAR, NOSE AND THROAT

A combined full time course covering an academic year (9 months) It consists of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver); clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients preoperatively and follow-up post operatively in the wards and clinics; attendance at departmental and general conferences. Also refresher courses (3 months).

For information for these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

W. C. Harris, Wood, to Milwaukee Hospital, 2200 North Kilbourn Avenue, Milwaukee.

Glenn A. Dall,* Milwaukee, to U.S.A.R., Medical Field Service School, Brooke A.M.C., Fort Sam Houston, Texas.

J. H. Huston, Wauwatosa, to 2702 Chamberlain Avenue, Madison.

J. A. Johnson, Fort Riley, Kansas, to Milwaukee County Guidance Clinic, 515 Public Safety Building, Milwaukee.

R. T. Cooney,* De Forest, to Hq. Co., I Corps Hq., A.P.O. 358, % Postmaster, San Francisco, California.

J. D. Sweeney, Sturgeon Bay, to 525 Fernwell Building, Spokane, Washington.

I. M. Becker,* Milwaukee, to 5353 Underwood, Oakland, California.

R. R. Redlin,* Corona, California, to L.S.T. Squadron 3, Naval Amphib. Base., Coronado, California.

P. W. Phillips,* La Crosse, to U.S.N.R., U.S. Naval Hospital, Portsmouth, Virginia.

E. M. Parkin, La Crosse, to 16 South Henry Street, Madison.

D. R. Becker, Fort Belvoir, Virginia, to 314 Madison Avenue, Fort Atkinson.

L. A. Van Ells, Brillion, to Wild Rose.

H. C. Dangle, Waukesha, to Marshfield Clinic, Marshfield.

W. H. Thiede,* Milwaukee, to U. S. Naval Hospital, Great Lakes, Illinois.

Charles Benkendorf,* Monticello, to U.S.N.R., Marine Wing Service, Squadron 3, Third Marine Aircraft Wing, M.C.A.S., Miami, Florida.

G. J. Hugo, West Allis, to 1053 Walnut Drive, Campbell, California.

P. D. Nelson,* Fort Sam Houston, Texas, to U.S.N. School of Aviation Medicine, U. S. Naval Air Station, Pensacola, Florida.

J. J. Brook, Jr.,* Marshfield, to 1516—15th Loop, Sandra Base, Albuquerque, New Mexico.

B. P. Ingersoll, Meriden, Mississippi, to 149 North Main, Adams.

Merle Q. Howard, Seattle, Washington, to Box 1670, Fort Sterlacoom, Washington.

J. A. Means,* Milwaukee, to Hq. and Hq. Detachment, Medical Activities, 8114 A. U. Ryukyus Army Hospital, A.P.O. 719, % Postmaster, San Francisco, California.

J. F. Klepfer, Waupun, to Richmond State Hospital, Richmond, Indiana.

J. M. Grindrod, Peshtigo, to Summit Hospital, Oconomowoc.

Howard Mauthe, Fond du Lac, to Ripon Municipal Hospital, Ripon.

J. W. Fulton, West Allis, to 7037 West Greenfield Avenue, Milwaukee.

H. E. Majeski, Casco, to Luxemburg.

* Military Service.

NERVOUS

The SUMMIT HOSPITAL
OCONOMOWOC, WIS.

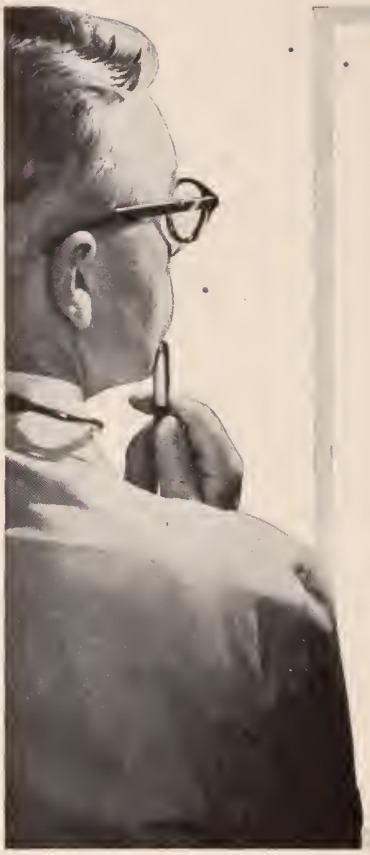
SENILE

For further information—
Director, Summit Hospital
Oconomowoc, Wisconsin

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:

1. High public acceptance as to flavor and palatability—billions eaten annually.
2. One of the best of the "protective" foods with a well-rounded supply of vitamins and minerals.
3. Low sodium—very little fat—no cholesterol.
4. Sealed by nature in a dust-proof package.
5. One of the first solid foods fed babies.
6. Can be easily digested by old folks as well as infants.
7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.
8. Can be baked, broiled or fried.
9. Can be used as an ingredient product in breads, pies, cakes and desserts.
10. Useful in bland and low-residue diets.
11. Mildly laxative.
12. May be used in the management of both diarrhea and constipation.
13. Can be used in reducing diets.
14. Can be used in high-calorie diets.
15. Useful in the dietary management of celiac disease.
16. Useful in the dietary management of idiopathic non-tropical sprue.
17. Useful in the management of diabetic diets.
18. Valuable in many allergy diets.
19. Belongs among foods useful in certain acute intestinal infections.
20. A protein sparer.
21. Favorably influences mineral retention.
22. Useful in the management of ulcer diets.
23. One of the easiest foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE



The answer is

B A N A N A S

If you would like

1. The authority for any of the statements made on the preceding page . . .

2. Additional information in connection with any of them...

3. The composition of the banana . . .

4. The nutritional story of the banana . . .

5. Information on various ways to prepare or serve bananas.

Please feel free to write to

Director, Chemical and Nutrition Research, United Fruit Company

PIER 3, NORTH RIVER, NEW YORK 6, N. Y.

DEATHS

Dr. Henry G. Westphal, who practiced in Polar, Langlade County, about 40 years ago, died on September 2 in Glendale, California.

Born in 1881, Doctor Westphal received his medical education at the American Medical Missionary College, from which he was graduated in 1905. He was a fellow of the American College of Surgeons. While in Wisconsin, he was for several years a member of the Langlade County Medical Society and the State Medical Society.

Dr. Eugene H. Townsend, retired La Crosse physician and surgeon, died at his home on October 23 after an extended illness.

Born in New Lisbon on March 14, 1891, Doctor Townsend was 62 years old at the time of his death. During his undergraduate days at the University of Wisconsin, from which he received a B.S. degree in 1914, he was for three years a member of Dr. William Snow Miller's Medical Historical Seminar. He was a 1917 graduate of Rush Medical School in Chicago. After a year's internship at St. Francis Hospital in La Crosse, he served in the Army Medical Corps until March 1919. On his discharge he practiced with his father in New Lisbon for about a year before moving to La Crosse. Doctor Townsend maintained his La Crosse practice until 1942, when total disability made it necessary for him to discontinue his work.

A member of county, state, and national medical societies, Doctor Townsend was a past president of the La Crosse County Medical Society. He was a former chief of staff and honorary member of St. Francis Hospital.

Surviving are his wife, Lillian; two sons, John F., who is serving in the Air Force, and Allan W., La Crosse; a daughter, Mrs. John C. Dwyer; and a sister, Mrs. Brand Starnes of New Lisbon.

Dr. James C. Tyvand, 76-year-old Whitehall physician, was killed October 26 in Arcadia when the car in which he and his wife were traveling was struck by a train.

Doctor Tyvand was born near Mount Horeb on April 2, 1877. On his graduation from the Chicago College of Physicians and Surgeons (now the University of Illinois College of Medicine) in 1902, he went to Milton, North Dakota, to set up his first practice. In 1907 he moved to Cheyenne Wells, Colorado, where he stayed for five years. Coming to Wisconsin, Doctor Tyvand and his family resided in Barneveld for a few years and then moved to Whitehall in 1916. With the exception of two years of military service with the Army Medical Corps

during World War I, he spent the rest of his medical career in Whitehall. Citizens of the community honored him last year on the occasion of his fiftieth year of practice.

A member of the Trempealeau–Jackson–Buffalo Counties Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, Doctor Tyvand was honored last year by his election to the Fifty Year Club of the state society.

The couple is survived by two sons, Paul of Arcadia and Lyman of Glen Ellyn, Illinois; a daughter, Mrs. Grant Fitch, of Glenview, Illinois; and five grandchildren.

Dr. Wellwood M. Nesbit, prominent Madison physician, died at his home on October 27 at the age of 63. He had been practicing in Madison for more than 30 years.

A specialist in ailments of the ear, nose, and throat, Doctor Nesbit was associated in practice with Dr. Mark E. Nesbit, his brother; Dr. Charles R. Taborsky, his son-in-law; and Drs. Ira R. Sisk, R. T. Cooksey, Samuel B. Harper, William B. Hobbins, and John B. Wear. In addition, he held an appointment as professor of otolaryngology at the University of Wisconsin Medical School. One of the first physicians to use the bronchoscope for removing foreign objects from the lung, Doctor Nesbit had patients brought to him from many parts of the country.

Doctor Nesbit was born on July 22, 1890, in Auburn, Iowa, and was graduated from Rush Medical College, Chicago, in 1917. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Nesbit's first wife died in 1946. He is survived by his wife, the former Mrs. George Cargill; and four daughters, Mrs. Charles R. Taborsky and Mrs. Joseph R. Usher of Madison; Mrs. H. J. Tausend, Houston, Texas; and Martha, Milwaukee.

Western Electric
HEARING AID
Air and Bone Conduction
There's a Western Electric Audiphone designed by the Bell Telephone Laboratories—embodying new principles, and exclusive features, to meet the individual needs of your patients.
Small, Inconspicuous, High Fidelity
AUDIOMETERS—ELECTRICAL STETHOSCOPE
AUDIPHONE UTILITIES
Suite 205 739 N. Broadway Daly 2505
MILWAUKEE

BOUGHT ANY NEW MEDICAL BOOKS LATELY?

Your older volumes would be gratefully received by the physicians, hospitals, and universities of Israel. Especially needed are books in the following categories, published since 1940:

All Medical Specialties
Anatomy
Aviation Medicine
Bacteriology
Biochemistry
Biology
Chemistry
Dentistry
Endocrinology
First Aid
General Practice
Gynecology and Obstetrics
Hospitals
Industrial Medicine
Internal Medicine
Medical Dictionaries
Mental Hygiene
Military and Naval Medicine
Nursing
Nutrition
Pathology
Personal Hygiene
Pharmacology
Physical Medicine
Physiology
Psychiatry
Psychology
Psychosomatic Medicine
Public Health
Surgery
Veterinary Medicine

If you can spare books on any of these subjects, please send them by prepaid parcel post to: BOOKS FOR ISRAEL, 115 King Street, New York 1, N. Y.

Note: Up to 70 pounds may be sent by parcel post, at 8¢ for the first pound and 4¢ for each additional pound, marked "Book Rate." Please give return address of individual or organization, so that your gift may be acknowledged. Funds for shipment from New York to Israel have been provided under Point IV, U. S. State Department, sponsors of this project.

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Oshkosh, April 23, 1953:

Name	*School of Graduation*	*Year*	*Address*
Alford, Richard M.	University of Michigan	1949	4505 N. Winchester, Chicago, Ill.
Bacon, Glenn Alfred	Northwestern University	1946	Racine
Doll, Stanley Garton	College of Evangelists	1949	Lancaster
Duncan, James T., Jr.	Washington University	1949	Kenosha National Bank Bldg., Kenosha
Gallen, William J.	Ohio State College	1948	721 N. 17th St., Milwaukee
Gericke, Julius T., Jr.	Marquette University	1943	American Nat. Bank Bldg., Eau Claire
Grace, James Eugene	Medical College of Virginia	1938	P. O. Box 49, Chelyan, W. Va.
Laibe, Joseph E. F.	University of Illinois	1922	Hayward
Marlow, Gordon V.	University of Wisconsin	1949	110 E. Main, Madison
Rosenblum, Alex M.	University of Pennsylvania	1944	8700 W. Wisconsin Ave., Milwaukee
Sherman, Carnot H.	Northwestern University	1919	Hudson Memorial Hospital, Hudson
Winkler, Lee F.	Washington University	1948	% C. E. Kampine, M.D., Marathon City

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Milwaukee, July 15, 1953:

Name	*School of Graduation*	*Year*	*Address*
Antonmattei, Jean C.	Marquette University	1944	4918 W. Wisconsin Ave., Milwaukee
Beck, Charles Arthur	St. Louis University	1942	1525 East 53rd St., Chicago
Bergwall, Warren Lund	Indiana University	1951	Denmark
Brown, Joseph Gregson	New York University	1950	Hardwick, Mass.
Burich, Harry Frank	University of Minnesota	1949	1836 South Ave., La Crosse
Clarke, Benjamin E.	University of Iowa	1925	St. Luke's Hospital, Milwaukee
Clay, Joel William	University of Michigan	1946	1031 First St., Menominee, Mich.
Copeland, Norman B.	Marquette University	1951	1920 John Ave., Superior
Durfee, Max Leo	University of Michigan	1930	3200 N. 36th St., Milwaukee
Genrich, Jeanne J.	Marquette University	1951	St. Mary's Hospital, Duluth 3, Minn.
Gordon, John Jegi	Creighton University	1950	New Richmond
Heersma, James Robert	Northwestern University	1949	1942 N. Mohawk, Chicago, Ill.
Hiatt, William R.	Indiana University	1950	Rte. 1, Box 304, Fond du Lac
Houlton, William H.	University of Minnesota	1952	425 E. 4th St., Proctor, Minn.
Holmes, Joel Grant	George Washington	1944	128 S. 4th Ave., Las Vegas, Nev.
Kiel, Alois Francis	Marquette University	1951	2317 S. Chase, Milwaukee
Lang, Charles Arthur	Northwestern University	1951	3438 Foster Ave., Chicago, Ill.
Leiby, Rowland W., Jr.	University of Rochester	1942	1836 South Ave., La Crosse
Martin, George J.	University of Wisconsin	1941	Norristown State Hospital, Norristown, Pa.
Middleman, Isadore C.	St. Louis University	1933	462 N. Taylor, St. Louis, Mo.
Montz, Charles R.	University of Iowa	1948	Marshfield Clinic, Marshfield
Nelson, Francis Dale	College of Medical Evangelists	1943	704 N. Main St., South Bend, Ind.
Patterson, Ingeborg	University of Cincinnati	1950	2223 E. Webster, Milwaukee
Prouty, Lawrence R.	Cornell University	1943	5718 Bittersweet Pl., Madison
Rideout, William Edward	Northwestern University	1929	State Bank Building, Freeport, Ill.
Rooney, James A.	Loyola University	1941	30 N. Michigan, Chicago, Ill.
Rose, William Russell	Meharry Medical College	1946	215 8th St., Waukegan, Ill.
Sayler, Jerome	Temple University	1950	Howard, S. D.
Schweitzer, Robert	Marquette University	1946	2144 N. 65th St., Wauwatosa
Shirey, John Kelly	Northwestern University	1951	Muirdale Sanatorium, Wauwatosa
Singh, Nerissa P.	Chicago Medical School	1950	5738 Maryland Ave., Chicago, Ill.
Smith, John Joseph	Columbia University	1949	Milwaukee County Hospital, Milwaukee
Smith, Thorsten	University of Minnesota	1934	615 Rand St., Chippewa Falls
Springer, Donald Welt	Loyola University	1945	First National Bank Bldg., Monroe
Ziel, Hermann A., Jr.	University of Pittsburgh	1946	Sheboygan Clinic, Sheboygan

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners on the dates indicated:

Name	*School of Graduation*	*Year*	*Address*
Buirge, Raymond E. 3/6/53	Duke University	1935	519 Physicians and Surgeons Building, Minneapolis, Minn.
Scott, Mildred E. 4/6/53	University of Kansas	1930	State Board of Health, Madison

At a meeting held in Milwaukee, July 14 to 16, 1953, the following physicians were granted licenses by the State Board of Medical Examiners:

Name	*School of Graduation*	*Year*	*Address*
Adams, Harold Gene	Marquette University	1952	Tomahawk
Arendt, Norbert William	University of Wisconsin	1952	511 Hooker, Wisconsin Rapids

Name	*School of Graduation*	*Year*	*Address*
Arkins, John Alex	University of Wisconsin	1952	4461 Murray, Milwaukee
Beil, Edward Joseph	Marquette University	1952	Eagle River
Bingham, Wilbur G., Jr.	University of Wisconsin	1952	3341 N. Summit, Milwaukee
Blizzard, Robert Martin	Northwestern University	1952	Wakonda Village, Des Moines, Ia.
Boulanger, Wayne J.	Marquette University	1952	3363 N. 47th, Milwaukee
Brown, Jack Donald	Marquette University	1952	206 Pine St., Sparta
Bruce, Reginald A.	Indiana University	1952	782 Edgemont, Indianapolis, Ind.
Caffrey, James Francis	Marquette University	1952	Rogers Sanitarium, Oconomowoc
Carroll, Paul Eagen	Marquette University	1952	Milwaukee Hospital, Milwaukee
Chamberlain, John O.	Marquette University	1952	3523 N. Freder, Milwaukee
Colburn, Robert C.	Washington University	1952	618 Myrtle, St., Janesville
Conley, Donal T.	Loyola University	1952	Milwaukee County Hospital, Milwaukee
Cops, James Murat	University of Wisconsin	1952	University Hospital, Madison
Craig, Carol Eifler	University of Wisconsin	1952	119 N. Hilbert, Cedarburg
Crawford, Chester W.	College of Medical Evangelists	1952	110 E. Main St., Madison
Crowley, William P., Jr.	University of Wisconsin	1952	2112 Jefferson, Madison
Cullen, Robert E.	University of Wisconsin	1952	1351 Rutledge, Madison
Daley, George M.	Marquette University	1952	4237 N. 44th, Milwaukee
Danford, Harold G.	University of Wisconsin	1952	1126 S. 7th, La Crosse
Derus, Gerald J.	University of Wisconsin	1952	4601 Monona Dr., Madison
Dorman, Thomas W.	Loyola University	1952	622½ Myrtle, Janesville
Evans, Harry C.	University of Wisconsin	1952	Genesee Depot
Evenson, Roland G.	Marquette University	1952	N. Central Ave., Marshfield
Falecki, Julian W.	Marquette University	1952	St. Joseph's Hospital, Milwaukee
Feierstein, William E.	Marquette University	1952	1012 S. 74th St., West Allis
Fenzl, Richard Paul	Marquette University	1952	147 Juniper, Lockport, N. Y.
Fitzsimmons, Joseph J.	Marquette University	1952	Columbia Hospital, Milwaukee
Freed, David Adolph	University of Wisconsin	1952	1104 W. "B" St., Iron Mountain, Mich.
Freeman, David Joe	University of Wisconsin	1952	503 Third St., Wausau
Gillings, Richard Leon	University of Washington Seattle	1952	7934 W. Appleton, Milwaukee
Goldberg, Seymour R.	University of Wisconsin	1952	Rio
Gorthey, Russell Leroy	Nebraska University	1951	2200 W. Kilbourn, Milwaukee
Gosin, Robert Fabian	Marquette University	1952	608 Minahan Bldg., Green Bay
Groh, Jack Edward	Marquette University	1952	3037 S. 62nd, Milwaukee
Habermann, James H.	Marquette University	1952	Mount Calvary
Hamel, Hubert H.	University of Wisconsin	1952	450 N. Few, Madison
Hansen, Raymond Lloyd	University of Wisconsin	1952	Colby
Hartlaub, Eugene S.	Loyola University	1952	60 S. Main, Janesville
Heffernan, Bart T., Jr.	Loyola University	1952	Milwaukee County Hospital, Milwaukee
Hendrickson, Robert L.	University of Wisconsin	1952	Wisconsin General Hospital, Madison
Horswill, C. Weir	University of Wisconsin	1952	Cadott
Hurley, John David	University of Wisconsin	1952	1938 N. 23rd, Milwaukee
Ironson, Herman Peter	University of Wisconsin	1952	1635 W. Morse, Chicago, Ill.
Jacobsen, Arthur J.	Marquette University	1952	1219 Center, Racine
Jennings, Thomas F.	Marquette University	1952	St. Joseph's Hospital, Milwaukee
Kebbekus, Robert Albert	University of Wisconsin	1952	22 Craig Ave., Madison
Koenig, Robert Ralph	University of Wisconsin	1952	3909 N. 5th, Milwaukee
Koppa, John Francis	Marquette University	1952	4238 N. 44th St., Milwaukee
Kuglitsch, Ervin F.	Marquette University	1952	Krohn Clinic, Black River Falls
Kuzdas, James Robert	Marquette University	1952	1936 N. 34th, Milwaukee
Lane, David Campbell	University of Tennessee	1951	1300 University Ave., Madison
Lardinois, Clifford C., Sr.	University of Wisconsin	1951	108 McMurray Rd., San Antonio, Tex.
Larsen, Harry Hedman	University of Wisconsin	1952	301 N. Main, Rice Lake
Leenhouts, Kenneth C.	Marquette University	1952	3042 N. 37th, Milwaukee
Leopold, Jay Virden	University of Wisconsin	1952	2808 N. 47th, Milwaukee
Lieberman, Donald	University of Wisconsin	1952	Knickerbocker Hotel, Milwaukee
Liebl, Edmund R.	University of Wisconsin	1952	113 N. Carroll, Madison
Lochowitz, Norbert J.	Marquette University	1952	2510 W. Capitol Dr., Milwaukee
Lubar, Sidney	Marquette University	1952	2952 N. 55th St., Milwaukee
Lynch, Thomas Sturgis	Jefferson Medical College	1952	79 Myrtle St., Oshkosh
MacDuffee, Frederic D.	Rochester University	1952	1815 Summit, Madison
Malone, John Albert	Marquette University	1952	2806 S. Herman, Milwaukee
Marks, Stanton Armin	Marquette University	1952	1618 N. 52nd, Milwaukee
Martin, John E., Jr.	Marquette University	1952	4319 W. Congress, Milwaukee
Marty, Philipp Henry	University of Wisconsin	1952	New Glarus
Mauch, Eugene William	Marquette University	1952	4303 N. 52nd, Milwaukee
McCormick, Thomas F.	Marquette University	1952	3800 N. Oakland, Milwaukee
McGary, Lester E.	University of Wisconsin	1952	2222 Hillington Green, Madison
McGinnis, James Philip	Marquette University	1952	4057 N. Sherman Blvd., Milwaukee
McNichols, Edwin F.	Loyola University	1952	4057 N. Sherman Blvd., Milwaukee
McPherson, Alice R.	University of Wisconsin	1951	Box 395, Butler
Meisekothen, William E.	Loyola University	1952	2805 E. Washington Ave., Madison
Meldman, Monte Jay	Marquette University	1952	4626 N. Morris Blvd., Milwaukee
Mendeloff, Elton	Marquette University	1952	3050–A N. 54th, Milwaukee

Upjohn

less-antigenic penicillin:

Cer-O-Cillin

Trademark Reg. U. S. Pat. Off. POTASSIUM

Available as:

Sterile vials containing 200,000 and 500,000 units Crystalline Penicillin O Potassium.

Bottles of 12 buffered tablets, each containing 100,000 units Crystalline Penicillin O Potassium.

Depo*-Cer-O-Cillin Chloroprocaine for Aqueous Injection in vials containing 1,500,000 units Crystalline Chloroprocaine Penicillin O.

*TRADEMARK, REG. U. S. PAT. OFF.

The Upjohn Company, Kalamazoo, Michigan

Name	School of Graduation	Year	Address
Merritt, James Woodward	State University of Iowa	1952	Luther Hospital, Eau Claire
Miller, Paul Louis	Marquette University	1952	4830 N. Port Washington Rd., Milwaukee
Newman, Chadwick C.	University of Wisconsin	1952	R.F.D. 2, Janesville
Niland, Paul Thomas	Marquette University	1952	627 N. 89th St., Milwaukee
Overton, Richard Stark	University of Wisconsin	1952	58 S. Main, Janesville
Parrish, John G., Jr.	Temple University	1952	426 Chippewa, Eau Claire
Petersen, George John	University of Wisconsin	1952	Hoyer Clinic, Beaver Dam
Peterson, Jack Arthur	University of Wisconsin	1952	555 E. Brown, Waupun
Prier, Thomas Arthur	Marquette University	1952	544 N. 33rd, Milwaukee
Ptacek, Louis J.	Marquette University	1952	3851 E. Plankinton Ave., Cudahy
Quandt, Courtney E.	Marquette University	1952	804 Linden, Jefferson
Richards, Williams G.	University of Wisconsin	1952	Apt. B., Wakonda Village, Des Moines, Ia.
Rosin, Louis Richard	Marquette University	1952	908 E. Third, Superior
Ross, Stanley Charles	University of Wisconsin	1952	722 W. Johnson, Madison
Roth, Donald Alfred	Marquette University	1952	9160 W. Hawthorne, Milwaukee
Ruwaldt, Mona Mae	Northwestern University	1952	618 N. 90th St., Milwaukee
Ryan, Thomas Edward	University of Wisconsin	1952	2105 Regent, Madison
Sabljak, Edward J.	Marquette University	1952	2427 S. 82nd, Milwaukee
Sanders, Arthur C., Jr.	Indiana University	1952	1117B W. Wright, Milwaukee
Sauer, John Philip	Marquette University	1952	St. Mary's Hospital, Milwaukee
Savage, George Walter	University of Wisconsin	1952	2200 W. Kilbourn, Milwaukee
Schilling, Stanley	University of Vermont	1952	1003 13th Ave., Monroe
Scheidt, Robert A.	Loyola University	1952	St. Joseph's Hospital, Marshfield
Schroeder, John Mason	University of Wisconsin	1951	1413 College Ave., Racine
Schroeder, Kenneth L.	University of Wisconsin	1952	817 N. Fair Oaks, Madison
Schuh, Eugene Paul	Northwestern University	1952	301 E. Milwaukee, Ft. Atkinson
Schuster, Benjamin	University of Wisconsin	1952	1 E. Gilman, Madison
Siefert, Clyde E.	Cincinnati University	1952	703 E. 4th, Marshfield
Smith, David Arthur	University of Wisconsin	1952	Milwaukee Hospital, Milwaukee
Sorensen, Ewald T.	University of Wisconsin	1952	Rte. 1, Box 13D, Wisconsin Dells
Szweda, John A.	Loyola University	1952	Lincoln Ave., Beaver Dam
Thimmig, Robert F.	University of Wisconsin	1952	VA Hospital, Wood
Truitt, Robert B.	Northwestern University	1952	3266 N. 95th, Milwaukee
Turner, Lewis III	University of Pittsburgh	1952	6827 5th Ave., Kenosha
Watzke, Robert Coit	University of Wisconsin	1952	130 Lathrop, Madison
Underriner, Margaret	University of Iowa	1952	Mendota State Hospital, Madison
Weidner, William A.	University of Wisconsin	1952	543 Jackson, Ft. Atkinson
Welter, Donald Joseph	Marquette University	1952	Shell Lake
Wichmann, Rodney	University of Wisconsin	1952	Eleva
Woods, William Craig	Marquette University	1952	4620 W. Hope, Milwaukee

The following physicians were granted licenses by the State Board of Medical Examiners on the dates indicated:

Name	School of Graduation	Year	Address
Cree, Edna Mabel 4/21/53	University of Wisconsin	1951	Wisconsin General Hospital, Madison
Roethke, Anne E. 3/13/53	University of Philadelphia	1952	8700 W. Wisconsin Ave. Milwaukee
Schuh, Ruth Romoser 4/22/53	Marquette University	1952	1428 N. 18th, Milwaukee
Thomas, Robert Henry 3/26/53	University of Pennsylvania	1951	Cook County Hospital, Chicago, Ill.

UNIVERSITY OF FLORIDA MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY AT MIAMI BEACH

The eighth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel, Miami Beach, from January 18 through 23, 1954. The first three days of the meeting, January 18, 19, and 20, will be devoted to lectures on ophthalmology; the lectures on otolaryngology will be given on January 21, 22, and 23.

Lecturers for the ophthalmology portion of this year's Seminar include W. B. Anderson, M. D., Durham, N. C.; W. P. Beetham, M. D., Boston, Mass.; W. C. Owens, M. D., Baltimore, Md.; and A. B. Reese, M. D., and M. C. Wheeler, M. D., New York City. Those lecturing on otolaryngology are E. N. Broyles, M. D., Baltimore, Md.; H. P. House, M. D., Los Angeles, Calif.; W. J. McNally, M. D., Montreal, Canada; and Dorothy Wolff, M. D., and De Graaf Woodman, M. D., New York City.

A midweek feature of the Seminar will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 20, to which all registrants are invited. An informal banquet for registrants and their wives has been arranged for Wednesday evening at 8:00. The Seminar schedule permits ample time for recreation.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

FOR SALE: 30 ma Continental x-ray and vertical fluoroscope, used, shock proof. Accessories include tank, hand timer, and cassette holder. Address replies to Box 517 in care of the Journal.

POSITION OPEN for otolaryngologist interested in clinic practice. Substantial retirement program and opportunity to become member of association without buying in. Salary open. Facilities of two hospitals available. Address replies to Box 531 in care of the Journal.

FOR SALE: General practice, office equipment, and records. Owner wishes to retire, will stay to introduce successor. Address replies to Box 532 in care of the Journal.

LOCUM TENENS wanted for 3 months or more. Years of experience in general practice. Address replies to Box 533 in care of the Journal.

PHYSICIAN AVAILABLE: Seven years of practice in Wisconsin with medicine as special interest. Military service obligations fulfilled. Wishes practice alone or with associate in moderate-sized community. Available immediately Write Box 505 in care of the Journal.

ASSOCIATE WANTED by busy general practitioner. Eventual partnership. Address replies to Box 534 in care of the Journal.

PRACTICE FOR SALE in southern Wisconsin town of 5,000, 9 miles from new and modern hospital facilities. Owner about to be called into service. Address replies to Box 507 in care of the Journal.

WANTED: General practitioner to join two-man group in thriving midwestern Wisconsin college community. Salary guaranteed first year, then partnership; new modern hospital facilities available. Address replies to Box 510 in care of the Journal.

OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

WANTED: Young, progressive clinic in western Wisconsin needs pediatrician, certified or board qualified, and a general practitioner. Excellent opportunity. Address replies to Box 521 in care of the Journal.

PHYSICIAN–SURGEON WANTED for industrial community serving 3,000 people within a 20-mile area. We will lease attractive doctor's residence and a fully equipped first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year, and his practice should increase each year thereafter. Available for immediate occupancy. Call or write the Goodman Lumber Company, Goodman, Wis.

FOR SALE: Practice and fully equipped 15-room office in central Wisconsin college town of 6,000. Gross over $40,000. New open hospital in city. Excellent for 3-man group. Because of health, owner will remain on part-time basis only. Address replies to Box 522 in care of the Journal.

FOR RENT OR SALE: Doctor's home, and office space in downtown office building. Also equipment. Good location for general or EENT practice in small city in year-round resort area with good hunting and fishing. Newly opened hospital in city. Address replies to Box 528 in care of the Journal.

WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

FOR SALE: Office building of late Dr. C. F. Peterson in Independence. Tile veneered, 21 by 46 ft., full basement, oil furnace. Beauty parlor upstairs could be converted into apartment. A few instruments for sale. Records go with instruments. Adddess replies to Box 524 in care of the Journal.

FOR SALE: Mobile 30 ma shockproof x-ray unit. Jones basal metabolism unit in excellent condition. Direct-writing electrocardiograph. Microscopes, new and used. Assorted cassettes with intensifying screens. Surplus x-ray filter grids, never used. FCC-approved short-wave diathermy units. Slightly used film filing cabinet. Write C. C. Remington, 1204 W. Walnut Street, Milwaukee.

INSTITUTIONAL position wanted by woman physician. Well trained in psychiatry, including shock treatments. Wisconsin license. Address replies to Box 525 in care of the Journal.

FOR RENT: Large one-room office suitable for consultant, particularly a psychiatrist, on one-day-a-week basis or full-time if desired. Active community in south central Wisconsin, with drawing population of 50,000. Office in professional building, has private bathroom and walk-in storage closet. Reasonable rental. Address replies to Box 526 in care of the Journal.

FOR SALE: General practice in Madison and complete office equipment. Owner retiring, will stay to introduce new physician. Address replies to Box 527 in care of the Journal.

FOR SALE: McCaskey Register System for physicians. Desk model, four drawers. Steel cabinet, 30½ by 17 by 32 inches. Price, $50.00. Address replies to H. G. E. Mallow, M. D., 210 Madison Ave., Fort Atkinson, Wis.

EXCELLENT OFFICE SPACE AVAILABLE for specialist in ENT, internal medicine, or radiology. Largest downtown building in Racine. Reasonable rental. Write or call Alex Wald, 610 W. Wisconsin Ave., Milwaukee, Wis.

FOR SALE to one purchaser: Entire office equipment of deceased general practitioner. Surgical equipment, furniture for 2 offices, 3 filing cabinets, instrument cabinet, new reception room furniture, 2 examining tables, 2 air conditioners, x-ray equipment, darkroom equipment, 2 scales. Address replies to Mrs. Paul Currer, 9405 Ridge Blvd., Wauwatosa 10, Wis. Tel. SPring 4–2686.

FOR SALE: X-ray machine built especially for head work. Darkroom equipment. Stainless steel operating table. 20 years' records of large EENT practice. Now stored in Wisconsin Rapids. Practice unopposed. Any reasonable offer accepted. Write to E. G. Barnet, M. D., 1011 Professional Bldg., Phoenix, Ariz.

CERTIFIED ELECTROCARDIOGRAPHER desires to interpret electrocardiograms by mail. Replies by return mail on day of receipt. $1.50 per interpretation. Address inquiries to Box 529 in care of the Journal.

PHYSICIANS, with or without public health training, and pediatricians needed in Maternal and Child Health program. Salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Write Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wisconsin.

FOR SALE: General practice in rural community of 2,000 people in southwestern Wisconsin. Estimated net income of $10,000 for first year. Will sell for value of inventory of office supplies and equipment. Housing facilities available in community. Address replies to Box 530 in care of the Journal.

Taste Toppers . . . for all ages

that's what physicians and patients alike call these two favorite dosage forms of Terramycin because of their unsurpassed good taste. They're nonalcoholic — a treat for patients of all ages, with their pleasant raspberry taste. And they're often the dosage forms of first choice for infants, children and adults of all ages.

Terramycin®

BRAND OF OXYTETRACYCLINE

Pediatric Drops

Each cc. contains 100 mg. of pure crystalline Terramycin. Supplied in 10 cc. bottles with special dropper calibrated at 25 mg. and 50 mg. May be administered directly or mixed with nonacidulated foods and liquids. Economical 1.0 gram size often provides the *total dose* required for treatment of infections of average severity in infants.

Supplied: Bottles of 1.0 Gm.

Oral Suspension *(Flavored)*

Each 5 cc. teaspoonful contains 250 mg. of pure crystalline Terramycin. Effective against gram-positive and gram-negative bacteria, including the important coli-aerogenes group, rickettsiae, certain large viruses and protozoa.

Supplied: Bottles of 1.5 Gm.

Pfizer **PFIZER LABORATORIES,** *Brooklyn 6, N. Y., Division, Chas. Pfizer & Co., Inc.*

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

Secretary ---------- R. F. Purtell, Milwaukee
Delegate ---------- George E. Forkin, Menasha
Alternate ---------- J. A. Grab, Sun Prairie

Section on Internal Medicine

Chairman ---------- M. A. Hardgrove, Milwaukee
Delegate ---------- R. N. Allin, Madison
Alternate ---------- R. A. Frisch, Milwaukee

Section on Neurology and Psychiatry

Chairman ---------- O. C. Clark, Oconomowoc
Delegate ---------- Harry Tabachnick, Milwaukee
Alternate ---------- E. Madison Paine, Green Bay
Secretary-Treasurer- J. T. Petersik, Winnebago

Section on Obstetrics and Gynecology

Delegate ---------- T. A. Leonard, Madison
Alternate ---------- Malcolm Hipke, Milwaukee
President ---------- F. J. Hofmeister, Milwaukee
Vice-President ----- G. H. Stevens, Wausau
Secretary-Treasurer- Alice D. Watts, Milwaukee
Board of Governors-- J. W. Prentice, Ashland
Robert McDonald, Milwaukee
T. A. Leonard, Madison

Section on Ophthalmology and Otolaryngology

Chairman ---------- John W. Doolittle, Madison
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- A. H. Pember, Janesville
Alternate ---------- E. J. Zeiss, Appleton

Section on Orthopedics

President ---------- W. P. Blount, Milwaukee
Secretary-Treasurer -- B. J. Brewer, Milwaukee
Delegate ---------- P. J. Collopy, Milwaukee
Alternate ---------- J. E. Miller, Madison

Section on Pathology

President ---------- E. A. Birge, Milwaukee
Vice-President ------ M. B. Llewellyn, Janesville
Secretary-Treasurer -- R. S. Haukohl, Milwaukee
Board of Censors ---- Etheldred, L. Schafer, Chairman, Madison
W. H. Jaeschke, Madison
S. B. Pessin, Milwaukee
Delegate ---------- Gorton Ritchie, Milwaukee
Alternate ---------- R. S. Haukohl, Milwaukee

Section on Pediatrics

Chairman ---------- E. H. Pawsat, Fond du Lac
Vice-Chairman ----- S. E. Kohn, Milwaukee
Secretary ---------- J. R. Schroder, Janesville
Delegate ---------- K. J. Winters, Wauwatosa
Alternate Delegate-- F. J. Mellencamp, Milwaukee

Section on Radiology

Chairman ---------- Abraham Melamed, Milwaukee
Vice-Chairman ----- R. W. Byrne, Milwaukee
Secretary-Treasurer C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- R. L. Troup, Green Bay

Section on Surgery

Delegate ---------- J. M. Sullivan, Milwaukee
Alternate ---------- M. G. Rice, Stevens Point
Chairman ---------- J. W. McRoberts, Sheboygan
Secretary ---------- J. G. Garland, Milwaukee

INDEX TO ADVERTISERS

Page

Abbott Laboratories ---------- 6, 7, 21
Audiphone Utilities ---------- 41
Ayerst, McKenna & Harrison, Ltd. ---------- 12

Barr X-Ray Company ---------- 34
Benson Optical Company ---------- 17
Bergmann Prescription Center ---------- 16

Central Drug ---------- 16
Chicago Medical Society ---------- 14

Coca-Cola Company ---------- 24
Cook County Graduate School of Medicine ------ 29

Doerflinger Artificial Limb Co. ---------- 37

Eaton Laboratories ---------- 10, 11
Endocrine Laboratories ---------- 24

Hotel Schroeder ---------- 17
House of Bidwell ---------- 32
Hurley X-Ray Company ---------- 5

Interstate Pharmacal Company ---------- 34

Keeley Institute ---------- 14
Kennedy–Mansfield ---------- 16

Lederle Laboratories ---------- facing page 42
Lilly, Eli and Company ---------- 18
Linde Air Products ---------- 33

Mallard, Incorporated ---------- 13
Mallatt Pharmacy ---------- 16
Mather Pharmacy ---------- 16
Mayer Drug ---------- 16
Mead Johnson and Company ---------- 59
Medical Protectice Company ---------- 24
Merck and Company ---------- 15
Milwaukee Sanitarium ---------- 60

New Orleans Graduate Medical Assembly -------- 4
New York Polyclinic ---------- 37

Orthopedic Appliance Company ---------- 32

Parke, Davis and Company ---------- 2, 3
Pfizer, Charles and Company, Inc. ---------- 47
Physicians Casualty Association ---------- 36
Pogue, Mary, School ---------- 34
Professional Business Service ---------- 707

Quincy X-Ray ---------- 37

Rennebohm's ---------- 16
Roemer Drug Company ---------- 17
Rogers Memorial Sanitarium ---------- 60

S. and L. Signal Company ---------- 32
Sacred Heart Sanitarium ---------- 35
St. Croixdale Sanitarium ---------- 5
Schieffelin and Company ---------- 29
Searle, G. D. and Company ---------- 19
Shorewood Hospital Sanitarium ---------- 31
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp. ---------- 8
Summit Hospital ---------- 38

Time Insurance Company ---------- 705

United Fruit Company ---------- 39, 40
Upjohn Company ---------- 44

Winthrop–Stearns, Inc. ---------- 9
Wisconsin Life Insurance Company ---------- 5

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

H. KENT TENNEY, Madison, President
A. J. McCAREY, Green Bay, President-Elect
L. O. SIMENSTAD, Osceola, Speaker
J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

R. G. ARVESON, Frederic, Chairman
S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954
First District:
W. H. Costello_____Beaver Dam
Second District:
T. C. Hemmingsen_____Racine

TERM EXPIRES 1955
Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954
H. E. Kasten_____Beloit

TERM EXPIRES 1955
Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955
Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1956
Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
R. E. Garrison__Wisconsin Rapids
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954
Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955
W. T. Casper_____Milwaukee

TERM EXPIRES 1956
Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1954
J. C. Griffith_____Milwaukee
(Past-President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1955

Alternates

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
G. E. Forkin, Menasha, 1955

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	W. J. Tucker Ashland	J. M. Jauquet 901 9th Ave., W. Ashland	
Barron-Washburn-Sawyer-Burnett	H. M. Templeton Barron	M. H. Sahs Spooner	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	S. M. Mokrohijsky St. Vincent's Hospital Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	C. A. Kemper 119½ Bridge Chippewa Falls	Paul Murphy Bloomer	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Colby	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafzlger Oxford	Second Tuesday 7:00 p.m.
Crawford	R. G. Konicek Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	S. L. Chase 905 University Ave. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	Leonard Schrank Waupun	R. F. Boock 119½ Front Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	W. H. Schuler Ripon	H. J. McLane 80 Sheboygan St. Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. L. Moffett Platteville	H. W. Carey Lancaster	Last Thursday. March, June, Sept. and Nov.
Green	N. E. Bear Monroe	D. E. Mings Monroe Clinic Monroe	
Green Lake-Waushara	A. C. Theiler Princeton	L. S. Shemanski Wautoma	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	O. H. Hanson 9 S. Water Fort Atkinson	H. N. Hunsader 111 S. Main Fort Atkinson	Third Thursday*

* Except June, July, and August.
** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. S. Hess Mauston	John E. Thompson Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. J. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	L. M. Gorenstein 402 Exchange Bldg. La Crosse	V. J. F. Bruder Gundersen Clinic La Crosse	Third Monday
Lafayette	L. L. Thompson Argyle	L. J. Unterholzner Blanchardville	Last Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	Walter Lewinnek 700 E. Third Merrill	J. D. Millenbah Merrill	
Manitowoc	W. H. Scherping 817 S. Eighth Manitowoc	D. M. Pick 926 Eighth Manitowoc	Last Thursday
Marathon	H. W. Christensen 501½ Third Wausau	J. M. Foerster 1024 Steuben Wausau	
Marinette–Florence	J. W. Boren 1510 Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	R. S. Irwin 425 E. Wisconsin Milwaukee	Alice D. Watts 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	F. E. Zantow Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	P. W. Limberg Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	H. A. Dasler Cornwall Clinic Amery	L. J. Weller. Osceola	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Rens Phillips	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	K. W. Covell 420 Seventh Racine	Eugene Pitts 420 Seventh Racine	Third Thursday
Richland	W. C. Edwards Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	Milton Davis Milton	H. M. Snodgrass 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	C. R. Pearson Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. R. Rivard 212½ S. Main Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. W. McRoberts 1011 N. Eighth Sheboygan	H. J. Winsauer 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	O. M. Schneider Blair	E. P. Rohde Galesville	Fourth Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	Laird McNeel Genoa City	G. O. Truex Darien	Second Thursday*
Washington–Ozaukee	R. H. Driessel West Bend	F. I. Bush West Bend	Fourth Thursday
Waukesha	Peter Theobald Oconomowoc	F. A. Thompson Waukesha	
Waupaca	J. H. Steiner 201 N. Main Waupaca	W. R. McInnis Marion	
Winnebago	J. R. Nebel 201 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	J. S. Vedder Marshfield	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.

INDEX

The Wisconsin Medical Journal

OWNED *and* PUBLISHED *by the* STATE MEDICAL SOCIETY *of* WISCONSIN

A Monthly Journal of Medicine and Surgery

Editorial Staff

R. S. BALDWIN, Marshfield, *Medical Editor*
J. M. SULLIVAN, Milwaukee, *Editorial Director*
MR. C. H. CROWNHART, Madison, *Managing Editor*
MR. ROY T. RAGATZ, Madison, *Advertising Manager*
MRS. DOROTHY P. REINHARDT, Madison, *Assistant Editor*

Editorial Board

D. W. OVITT, Milwaukee
ELWOOD MASON, Milwaukee
FRANK WEEKS, Ashland
G. A. COOPER, Madison
V. S. FALK, Edgerton

The Council on Scientific Work

J. W. GALE, Madison, Chairman
P. A. MIDELFART, Eau Claire
S. A. MORTON, Milwaukee
M. G. RICE, Stevens Point
L. G. KINDSCHI, Monroe
R. S BALDWIN, Marshfield, (ex officio)
J. S. HIRSCHBOECK, Milwaukee, (ex officio)
W. S. MIDDLETON, Madison, (ex officio)

VOLUME LII
JANUARY 1953—DECEMBER 1953

INDEX VOL. LII, 1953*

Authors

Page

Albright, E. C., Madison 631
Allen, John, Madison 593
Anderson, W. A. D., Milwaukee 151, 253
Angevine, D. M., Madison 209, 284, 395, 535, 611
Ansfield, Maurice J., Milwaukee 199

Barnes, Allan C., Columbus, Ohio 232
Barrock, James J., Milwaukee 179
Barry, G. R., Monroe 235
Beckman, Harry, Milwaukee 157, 208, 247, 290, 334
Beezy, Reuben, Wood 322
Belfus, Frank, Milwaukee 373
Benjamin, H. B., Milwaukee 277
Bennett, Maxine, Madison 137
Betlach, Dorothy W., Janesville 248, 437, 634
Blum, O. S., Monroe 235
Borge, Alf F., South Bend, Ind. 129
Boudry, M. O., Waupaca 620
Buchman, D. M., La Crosse 265

Cameron, Eugenia S., Madison 440
Chambers, Catherine, Madison 636
Ciccantelli, Mark J., Wood 322
Cleveland, David, Milwaukee 629
Cline, Frances A., Rhinelander 129
Curry, James C., Milwaukee 597

Davidsohn, Israel, Chicago 187
Dedinsky, Gilbert, Smock, Pa. 389

Eckstam, E. E., Monroe 235
Erbes, John, Milwaukee 270

Fazen, Louis E., Racine 429
Feig, Milton, Madison 383
Filek, Allan, Madison 615
Fox, Max J., Milwaukee 313, 487,

Gallagher, Raymond C., Jr., Janesville 219
Griffith, J. C., Milwaukee
3, 161, 215, 261, 312, 359, 423, 478, 9–24

Hardgrove, Maurice, Milwaukee 626
Hassett, Donald D., Evergreen Park, Ill. 479
Hilding, A. C., Duluth, Minn. 165
Hodgson, Edward R., Madison 14
Holbrook, Arthur Andrews, Milwaukee 425, 546
Hunter, Amy Louise, Madison 491

Ihle, Charles M., Eau Claire 229

Jennings, Janet, Madison 190
Jensen, Agnes G., Madison 562
Jochimsen, Earl, Madison 487
Johnson, J. W., Withee 541

Kiefer, Edward J., Milwaukee 629
Kline, Carl L., Milwaukee 482
Koch, Vincent W., Janesville 219
Kohler, Gov. Walter J. 337
Krumenacher, Fred P., Milwaukee 373
Kuzma, J. F., Milwaukee 327, 467, 555, 638

Page

Lea, William L., Madison 289
Leucutia, Traian, Detroit, Mich. 623
Linton, Robert R., Brookline, Mass. 149

Magnin, G. E., Marshfield 120
McEnery, E. T., Chicago 175
Mengert, William F., Dallas, Texas 392
Meyer, Ovid O., Madison 120, 601
Mings, D. E., Monroe 235
Moskowitz, Irwin, Madison 313
Muegge, O. J., Madison 419
Munn, Wayne A., Janesville 219
Muskat, Irving, Milwaukee 587

O'Meara, Mark T., La Crosse 381
Otto, Owen, Milwaukee 171
Overgard, Albon W., Stanley 541

Petters, W. J., Waupun 128
Pleyte, A. A., Milwaukee 251, 549
Pollard, H. Marvin, Ann Arbor, Mich. 325
Prouty, Margaret, Madison 317

Quandt, Valerius V., Hartford 225

Rasmussen, A. F., Jr., Los Angeles 129
Reese, Hans H., Madison 14
Regan, Louis J. 26
Richtsmeier, Anthony J., Madison 593
Rosenthal, Samuel, Milwaukee 225
Rotter, Royal, Madison 120

Sagi, Joseph H., Milwaukee 373
Sander, O. A., Milwaukee 251
Schneider, Chester C., Milwaukee 81
Schrank, L. W., Waupun 128
Schrank, R. E., Waupun 128
Schwade, Edward D., Milwaukee 171
Sinsky, John E., Milwaukee 184
Smiles, William J., Ashland 322
Steeper, John R., Madison 117
Sternitzky, Duane, Milwaukee 549
Stiles, F. C., Monroe 235, 543
Stoddard, F. Jackson, Milwaukee 434
Stovall, W. D., Madison 238
Sullivan, James M., Milwaukee 281

Tatum, A. L., Madison 417, 441, 533, 553
Tenney, H. Kent, Madison 585
Thomson, Vernon W. (Attorney General) 11, 22
Tomlinson, Carol, Janesville 219

Van Duser, A. L., Madison 335

Wagner, Marvin, Milwaukee 277
Wagner, W. A., Waupun 128
Washburne, Annette C., Madison 133
Weir, J. R., Monroe 235
Weisel, Wilson, Milwaukee 389
White, Ellison F., Statesan 140

* Wherever a number such as 4–42 appears, the first number refers to the month, the second number to the page.

Articles (asterisks denote editorials)

Page

ACNE VULGARIS in teen-age males, The treatment of, with oral and topical administration of estrogenic hormone, Holbrook ---------- 425
ACTH (corticotropin) and cortisone, General uses of, Sagi, Belfus, and Krumenacher -------- 373
ACUTE PNEUMONIA ---------- 322
ADDISON'S DISEASE with protracted unusual mental changes, Quandt and Rosenthal ---------- 225
ADOLESCENT GIRLS, Recognizing emotional problems in ---------- 482
ADOPTION PROCEDURES in Wisconsin ---------- 68
Advertisers, Index to ----------1–40, 2–48, 3–46, 4–42, 5–52, 6–44, 7–48, 8–46, 9–46, 10–44, 11–46, 12–48
AEROSOL THERAPY in children, Stiles ---------- 543
Important note to readers of ---------- 596
AMERICAN MEDICAL ASSOCIATION
—— News notes ----------2–47, 3–45, 4–41, 5–25, 6–27, 7–29, 477, 9–25, 10–35, 621, 12–23
—— Officers (1952–53) of the ---------- 116
—— Principles of medical ethics of the ---------- 111
ANESTHESIA disturbances, Preventable, Betlach --- 437
—— study commission, Wisconsin ----------248, 437, 634
ANTIBIOTICS
—— More on abuse of, Tatum ---------- 553
—— Reactions to, Tatum ---------- 417
ANTIHISTAMINIC DRUGS in dermatology ---------- 179
ANTI-TUBERCULOSIS ASSOCIATION, Wisconsin, Changes in medical policies of ---------- 251
ARTERITIS, Temporal, Curry ---------- 597
As it looks to your state board of health --140, 190, 238, 289, 335, 419, 440, 491, 562, 615, 636

BILLROTH I PARTIAL GASTRECTOMY, Indications for the, Fazen ---------- 429
BIOPSY, Needle, of the liver, Buchman ---------- 265
BLOOD TEST, Identification by ---------- 38
BLUE SHIELD OF WISCONSIN, Facts about ----------158, 218, 264, 5–28, 336, 420, 8–24, 490, 564
See also Wisconsin Physicians Service

Book Reviews

Antibiotic therapy ---------- 6–39
Bacteriology, Diagnostic ---------- 10–40
Biological antagonism: theory of biological relativity ---------- 5–48
Blood, Standard values in ---------- 10–36
Bone tumors ---------- 6–41
Brain surgeon, autobiography of William Sharpe, M.D. ---------- 10–38
Cardiac therapy ---------- 11–38
Clinical use of fluid and electrolyte, The ------- 5–47
Dermatology, Essentials of ---------- 10–40
Dermatology, Practical ---------- 7–44
Diabetes, Your; a complete manual for patients 1–31
Endocrinology, Research in ---------- 1–34
Histopathological technic ---------- 1–34
Human embryology ---------- 6–39
Living in balance ---------- 10–36
Medical clinics of North America (Boston number) ---------- 7–44
Medical clinics of North America (Los Angeles number) ---------- 7–42
Medical clinics of North America (Philadelphia number) ---------- 7–44
Medical clinics of North America (Tulane–Toronto number) ---------- 10–40
Medical papyri, The old Egyptian ---------- 1–34
Medical statistics, Elementary, the principles of quantitative medicine ---------- 1–34
Medicine ---------- 9–41
Medicine and surgery, Advances in ---------- 6–40
Neuroanatomy, Correlative, and functional neurology ---------- 7–42
Neurology, Textbook of clinical ---------- 11–40
Ophthalmic pathology: an atlas and textbook -- 10–36
Origin of life and the evolution of living things, The ---------- 5–47
Orthopedics, A textbook of, with a section on neurology in orthopedics ---------- 6–40
Pardon my sneeze ---------- 6–40
Penicillin decade ---------- 7–43
Physiology, Basic medical ---------- 1–31
Prescription for medical writing ---------- 5–48
Principles of refraction ---------- 6–41
Psychiatric clinic patients, Vocational services for 1–32
Psychiatry, Fundamentals of ---------- 11–38
Psychiatry and medical education ---------- 9–42
Remedies, New and nonofficial ---------- 1–32
Scalp in health and disease, The ---------- 1–36
Science of health, The ---------- 7–43
Therapy, Current, 1952 ---------- 7–42

Page

Trauma in the armed forces, Symposium of treatment of ---------- 11–42
Tuberculosis, A 40 year campaign against ------ 6–39
Unipolar electrocardiogram, The ---------- 5–48
CANCER, Newer developments in radiation therapy of Leucutia ---------- 623
CARCINOMA OF THE RECTOSIGMOID in selected cases, Surgery of, Benjamin and Wagner -------- 277
CARDIAC ARREST in the pediatric patient, Betlach -- 248
—— and resuscitation, Eckstam and others ------- 235
CARDIAC PATIENT, Home nursing for the ---------- 190
CEREBRAL HEMORRHAGE, maternal, complicating pregnancy, Fetal salvage in a fatal case of 479
CHEST X-RAYING of general hospital admissions, Jensen ---------- 562
CHILD PLACEMENT, Physicians and ---------- 79
CHILDREN, Aerosol therapy in ---------- 543
—— dangers of codeine overdosage in, The ------ 487
—— Protein needs in, premature and pre-school groups ---------- 175
CHILDREN'S EMOTIONAL PROBLEMS, Role of family physician in, Cameron ---------- 440
CIVIL DEFENSE—progress in medical supplies, Van Duser ---------- 335
Clinicopathologic conference 151, 209, 253, 284, 327, 395, 467, 535, 555, 611, 638
COCHLEAR ANATOMY, Some new points in, and their physiologic implications, Hilding ---------- 165
CODEINE OVERDOSAGE in children, The dangers of, Fox and Jochimsen ---------- 487
Comments on treatment ------157, 208, 247, 290, 324, 417, 441, 533, 553, 601
Comments from the Wisconsin press -------160, 214, 258
See also Wisconsin Press–Commentator, The
COMMUNICABLE DISEASE RULES, State board of health services and ---------- 39
CONGENITAL ESOPHAGEAL ATRESIA with tracheo-esophageal fistula and associated pectus excavatum, prematurity, and right aortic arch 389
CORONARY EPISODES, acute, Usefulness and hazards in the current and popular methods of treatment in cases of, Tatum ---------- 533
CORONARY THROMBOSIS, Does exertion precipitate? Tatum ---------- 441
Correspondence ----------1–29, 10–31
CORTISONE, General uses of ACTH (corticotropin) and ---------- 373
COXSACKIE VIRUS INFECTIONS in northern Wisconsin, Rasmussen, Cline, and Borge ---------- 129

Deadlines and other "musts," Your ---------- 67
DEATH CERTIFICATE, Signing of, if no attending physician, Thomson ---------- 22
DECOMPRESSION of the ganglion and posterior root of the fifth nerve for trigeminal neuralgia -- 629
DEGENERATIVE DISEASE of the hip joint ---------- 229
DERMATOLOGY, Antihistaminic drugs in, Barrock -- 179
DESMOID TUMORS, Steeper ---------- 117
DEXTRAN replaces plasma* ---------- 422
DIAGNOSIS of illness due to excessive lead absorption, The ---------- 289
DIETARY MANAGEMENT of the pregnant patient, The 232
DISABILITY EVALUATION, Schneider ---------- 81
DISEASE CONTROL, Environmental sanitation and -- 419
DRUG THERAPY, Questions and answers suggested by recent investigations in, Beckman -----247, 334
—— of infectious diseases, Some 1952 developments in the, Beckman ---------- 157
—— Some other 1952 developments in, Beckman -- 208
DRUGS, Antihistaminic, in dermatology ---------- 179
—— Dispensing of, by physicians and their employees, Thomson ---------- 11

Editorials

Dates to Remember in 1954 ---------- 758
Dextran replaces plasma ---------- 422
Dr. Neupert, a refreshing choice ---------- 311
Ethics of peeve splitting, The ---------- 357
Fluorine in the drinking water ---------- 540
Free choice of physicians ---------- 620
Hernia problem ---------- 213
How much will it cost? ---------- 582
Medical society license plan hit ---------- 259
Needless referrals ---------- 757
New York meeting, The ---------- 311
Nurse recruitment ---------- 422
Open letter to American Medical Association --- 357

Page
Political medicos 475
Priceless, yet free 213
Razor's edge, The 421
Rx for better doctors 159
Thanks, Mr. Editor 358
There is a use 260
What lies ahead? 63
What's the use? 159

ELECTROENCEPHALOGRAPHIC FINDINGS, abnormal, Homicide as a manifestation of thalamic or hypothalamic disorder with 171
EMOTIONAL ILLNESS, practical methods for the diagnosis and treatment of, Washburne 133
EMOTIONAL PROBLEMS in adolescent girls, Recognizing, Kline 482
— children's, Role of family physician in 440
ENVIRONMENTAL SANITATION and disease control 419
EPIDEMIOLOGIC ASPECTS OF POLIOMYELITIS in Wisconsin, 1947–1952, Some 383
EPILEPTICS and the state motor vehicle department 85
ESOPHAGEAL ATRESIA, Congenital, with tracheoesophageal fistula and associated pectus excavatum, prematurity, and right aortic arch, Weisel and Dedinsky 389
ESOPHAGEAL VARICES, bleeding, The surgical treatment of, Linton 149
ESTROGENIC HORMONE, The treatment of acne vulgaris in teen-age males with oral and topical administration of 425

FAMILY PHYSICIAN, Role of, in children's emotional problems 440
FETAL SALVAGE in a fatal case of maternal cerebral hemorrhage complicating pregnancy, Hassett 479
FLUORINE in the drinking water* 540
FOLIC ACID ANTAGONISTS, The treatment of acute leukemia with combined steroid hormones and 120

GAMMA GLOBULIN for mass immunization, Criteria for the procurement of 471
— for measles and infectious hepatitis prophylaxis, Distribution of 11–36
— and poliomyelitis 223
GASTRECTOMY, Billroth I partial, Indications for the 429
GLYCOGEN DISEASE, Hepatorenal 593

HEALTH examination programs for employees of Wisconsin schools, Development of, Pleyte and Sternitzky 549
— program, school, The physician and the 491
— Wisconsin, Governor Kohler speaks on 337
HEARING CONSERVATION in industry, Clinics on, announced 474
— Program, a study and evaluation of 97 selected cases seen at otologic clinics in the 137
HEART STRAIN, Skiing and, Holbrook 546
HEMORRHAGE, Nasal 587
HEPATITIS, Homologous serum, Ansfield 199
HEPATORENAL GLYCOGEN DISEASE, Richtsmeier and Allen 593
HERNIA, inguinal, in infancy and childhood, The treatment of, O'Meara 381
— Lumbar, Koch and others 219
— problem* 213
HIP JOINT, Degenerative disease of the, Ihle 229
HOMOLOGOUS SERUM HEPATITIS 199
HORMONE, The treatment of acne vulgaris in teen-age males with oral and topical administration of estrogenic 425
HORMONES, steroid, and folic acid antagonists, The treatment of acute leukemia with combined 120
HOSPITALS, University 83
HYSTERIA in poliomyelitis 313

IMMUNIZATION, mass, Criteria for the procurement of gamma globulin for 471
INCOME TAX provisions affecting the medical profession 642
Index to advertisers
See Advertisers, Index to
INDUSTRIAL NURSING SERVICES in Wisconsin 636
INFANCY AND CHILDHOOD, The treatment of inguinal hernia in 381
INFECTIOUS DISEASES, Some 1952 developments in the drug therapy of 157
INGUINAL HERNIA in infancy and childhood, The treatment of 381

Page
INTESTINAL OBSTRUCTION, High, in the newborn, Erbes 270
IODINE, radioactive, Treatment of thyrotoxicosis with 631

Journal Bookshelf, The
See Book Reviews

LEAD ABSORPTION, The diagnosis of illness due to excessive 289
LEUKEMIA, acute, The treatment of, with combined steroid hormones and folic acid antagonists, Magnin, Rotter, and Meyer 120
— and its complications, Hardgrove 626
LICENTATES, Recent Wisconsin 7–26, 12–42
LIVER, Needle biopsy of the 265
LUMBAR HERNIA 219

MALPRACTICE and the physician, Regan 26
"MARCH OF MEDICINE," Schedule of programs of the 21, 186, 252, 280, 324, 418, 433, 481, 552, 616, 750
MATERNAL CEREBRAL HEMORRHAGE complicating pregnancy, Fetal salvage in a fatal case of 479
MEDICAL CARE, Civilian, for army, navy, and air force personnel and their dependents 34
MESENTERIC VASCULAR OCCLUSION 541
MONONUCLEOSIS, infectious, Differential diagnostic problems in, Davidsohn 187

NARCOTICS, Prescription of 110
NASAL HEMORRHAGE, Muskat 587
NECROPSY procedure, Code of 23
NERVE INJURIES, Betlach 634
NEURALGIA, trigeminal, Decompression of the ganglion and posterior root of the fifth nerve for, Cleveland and Kiefer 629
NURSE RECRUITMENT 422
NURSING, Home, for the cardiac patient 190
NURSING SERVICES IN WISCONSIN, Industrial, Chambers 636

OCCLUSION, Mesenteric vascular, Overgard and Johnson 541
OFFICERS OF STATE BOARDS AND COMMISSIONS 64
OTOLOGIC CLINICS in the Wisconsin Hearing Conservation Program, a study and evaluation of 97 selected cases, Bennett 137
OVARIAN TUMORS, Clinical aspects of, Mengert 392

PARTNERSHIPS, Medical 75
PEDIATRIC PATIENT, Cardiac arrest in the 248
PEPTIC ULCER, Therapy not to employ in the treatment of 325
PNEUMONIA, Acute, Beezy, Ciccantelli, and Smiles 322
POLIOMYELITIS, Gamma globulin and 223
— Hysteria in, Fox and Moskowitz 313
— Present concepts of, Prouty 317
— in Wisconsin, 1947–1952, Some epidemiologic aspects of, Feig 383
POSTMORTEM EXAMINATION 80
PREGNANCY, Acute urinary retention in 128
— Fetal salvage in a fatal case of maternal cerebral hemorrhage complicating 479
PREGNANT PATIENT, The dietary management of the, Barnes 232
PRESENTATION, Transverse 184
Proceedings of the Milwaukee Academy of Medicine 149, 187, 325, 392
PROTEIN NEEDS IN CHILDREN, premature and preschool groups, McEnery 175
PSYCHIATRIST IN COURT, The, Reese and Hodgson 14
PUBLIC HEALTH (Wisconsin), A directory of voluntary and governmental agencies in the field of 4
RADIATION THERAPY OF CANCER, Newer developments in 623
RADIOACTIVE IODINE, Treatment of thyrotoxicosis with 631
RECTOSIGMOID, Surgery of carcinoma of the, in selected cases 277
RESEARCH, Donations and bequests for 71
RESPIRATORS (iron lungs), Home location of, throughout Wisconsin 1–30
ROOMING-IN and the private hospital, Stoddard 434

Page

SALARY CEILINGS and doctors ---- 90
SANITATION, Environmental, and disease control, Muegge ---- 419
SCHOOL HEALTH PROGRAM, The physician and the, Hunter ---- 491
SCHOOLS, Wisconsin, Development of health examination programs for employees of ---- 549
SILVER NITRATE, Physicians advised on substitution of ---- 70
SKIING and heart strain ---- 546
SOCIAL SECURITY BENEFITS for doctors ---- 103
STATE BOARD OF HEALTH services and communicable disease rules ---- 39
STATE BOARDS and commissions, Officers of ---- 64
STATE LABORATORY OF HYGIENE dedication ceremony, Madison, Feb. 28, 1953 ---- 299
STATE LABORATORY SERVICES, A change in ---- 238

State Medical Society of Wisconsin

Annual meeting, 1953 ---- 307, 349, 409, 443, 493
Annual dinner ---- 310, 411, 501
Exhibits
Scientific ---- 162, 216, 262, 454, 513
Technical ---- 458, 517
House of Delegates ---- 502
Woman's Auxiliary program ---- 523
Charter law of medical societies in Wisconsin -- 87
Clinics, Postgraduate ---- 164, 3–27
Committee concentrates ---- 2–24, 3–24, 4–24, 5–30, 6–24, 7–22, 8–26, 9–28, 563, 12–25
Constitution and by-laws of the ---- 104
Council award, recipients of the ---- 1–30
Council meeting, minutes
February 28–March 1, 1953 (Madison) ---- 361
May 23–24, 1953 (Madison) ---- 573
August 1–2, 1953 (Land O'Lakes) ---- 617
October 4 (Milwaukee) ---- 745
October 7 (Milwaukee) ---- 749
November 21–22 (Madison) ---- 751
Councilor districts, map indicating location of -- 91
County medical societies, officers and scheduled meetings of ---- 1–41, 2–49, 3–47, 4–43, 5–53, 6–45, 7–49, 8–47, 9–47, 10–45, 11–47, 12–49
Deaths ---- 2–42, 3–40, 4–38, 5–45, 6–37, 7–39, 8–37, 9–38, 10–28, 11–32, 12–40
Disability plan ---- 86
First statutory recognition of ---- 87
House of Delegates
Attendance at, Milwaukee, Oct. 5, 6, 7, 1953 -- 743
Message to the, Tenney ---- 585
Transactions of the 1953 regular session ---- 663
Marriages ---- 2–41, 6–36, 10–28, 12–37
Members ---- 92
News items and personals ---- 2–34, 3–32, 4–30, 5–36, 6–30, 7–32, 8–30, 9–32, 10–20, 11–24, 12–30
Officers and chairmen of Woman's Auxiliary (1952–53) ---- 524
Officers and councilors (1953) ---- 88, 497
Officers of sections ---- 1–40, 2–48, 3–46, 4–42, 5–52, 6–44, 7–48, 8–46, 9–46, 10–44, 11–46, 12–48
Past presidents ---- 1–26
Physicians' exchange ---- 1–39, 2–46, 3–44, 4–40, 5–50, 6–42, 7–46, 8–44, 9–44, 10–42, 11–44, 12–46
President's page, The 3, 161, 215, 261, 312, 359, 423, 478, 9–24, 583, 12–20

Society Proceedings

Ashland–Bayfield–Iron ---- 5–34, 7–30, 8–28, 9–32
Barron–Washburn–Sawyer–Burnett -- 2–30, 3–28, 6–28
Brown–Kewaunee–Door -- 2–30, 3–28, 5–34, 10–20, 12–28
Calumet ---- 2–30, 5–34, 6–28
Chippewa ---- 2–30
Columbia–Marquette–Adams ---- 6–34
Crawford ---- 8–28
Dane ---- 3–36, 7–36
Dodge ---- 2–30, 4–27, 12–28
Douglas ---- 3–28, 12–28
Fond du Lac ---- 2–30, 3–28, 4–27, 6–28, 12–28
Grant ---- 5–34
Green ---- 9–35
Green Lake–Waushara -- 2–32, 4–27, 6–28, 8–28, 12–28
Jefferson ---- 2–30
Kenosha 2–32, 3–28, 4–27, 5–34, 6–28, 8–28, 11–24, 12–23
La Crosse ---- 2–32
Lafayette ---- 2–22
Lincoln ---- 2–22
Manitowoc ---- 2–32, 3–28, 4–27, 7–30
Marathon ---- 2–32
Marinette–Florence ---- 3–28, 5–34, 8–28
Milwaukee ---- 2–40, 3–37, 4–36, 5–43, 7–37, 12–36
Oconto ---- 12–28

Page

Outagamie ---- 4–27, 7–30, 11–24
Pierce–St. Croix ---- 5–34, 12–28
Polk ---- 2–33
Price–Taylor ---- 2–33, 4–27, 7–30, 10–20
Racine ---- 3–28, 4–27
Richland ---- 2–33, 3–28, 5–34, 6–28, 7–30
Rock ---- 6–34, 8–36
Sauk ---- 2–39, 3–36, 4–35, 5–42, 6–35
Shawano ---- 2–33, 3–28, 5–34, 6–28
Sheboygan ---- 4–28
Trempealeau–Jackson–Buffalo ---- 2–33, 3–28, 4–28, 5–34, 6–28, 8–28
Walworth ---- 2–33, 5–36
Waupaca ---- 2–33, 7–30
Winnebago ---- 2–33, 3–28, 4–28, 5–36, 6–28, 8–28, 10–20, 11–24
Wood ---- 2–33, 4–28
American Academy of General Practice, Appleton Chapter ---- 12–29
Eleventh Councilor District ---- 9–32
Manitowoc Academy of Medicine ---- 6–28
Milwaukee Academy of Medicine ---- 2–41, 3–38, 4–37, 5–43, 6–35, 12–36
Milwaukee County Hospital Intern and Resident Association ---- 6–36
Milwaukee Neuro-Psychiatric Society ---- 2–41, 4–37, 5–43, 6–36, 12–36
Milwaukee Oto-Ophthalmic Society ---- 3–38, 4–37, 6–36, 8–36, 12–36
Multiple Sclerosis Society of Milwaukee ---- 12–37
Section on Neurology and Psychiatry ---- 12–29
Sherrington Society ---- 5–42
Wisconsin Academy of General Practice ---- 12–29
Wisconsin Academy of General Practice, Manitowoc Chapter ---- 4–28, 9–32
Wisconsin Heart Association ---- 7–30
Wisconsin Society of Obstetrics and Gynecology 7–31
Wisconsin Society of Pathologists ---- 8–28
Wisconsin State Radiological Society ---- 7–31
Wisconsin Surgical Club ---- 4–28
Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology ---- 8–30, 11–24
Wisconsin Urological Society ---- 6–28
Society records ---- 2–41, 3–38, 4–37, 5–44, 6–36, 7–38, 8–37, 9–36, 10–28, 11–31, 12–37
Standing committees, 1952–1953 ---- 89
Third and Twelfth Districts News ---- 2–37, 3–34, 4–34, 5–40, 6–33, 7–35, 8–35, 9–34, 10–26, 11–27, 12–32
STUDENT LOAN FUND, The ---- 69
SURGERY of carcinoma of the rectosigmoid in selected cases ---- 277
—— Strabismus, and repair of pectus excavatum -- 235

TAX DEDUCTIONS for health expenses ---- 85
TEMPORAL ARTERITIS ---- 597
THALAMIC OR HYPOTHALAMIC DISORDER with abnormal electroencephalographic findings, Homicide as a manifestation of, Schwade and Otto 171
THERAPY not to employ in the treatment of peptic ulcer ---- 325
THYROTOXICOSIS, Treatment of, with radioactive iodine, Albright ---- 631
TRANSVERSE PRESENTATION, Sinsky ---- 184
TREATMENT in cases of acute coronary episodes, Usefulness and hazards in the current and popular methods of ---- 533
TUBERCULOSIS, Changing trends in the treatment of, White ---- 140
TUMORS, Desmoid ---- 117
—— ovarian, Clinical aspects of ---- 392

ULCER, peptic, Therapy not to employ in the treatment of, Pollard ---- 325
UNIVERSITY HOSPITALS ---- 83
URINARY RETENTION in pregnancy, Acute, Petters, Schrank, Wagner, and Schrank ---- 128

VARICES, The surgical treatment of bleeding esophageal ---- 149
VARICOSE VEINS, Further experiences with vein stripping for, Sullivan ---- 281
VIRUS INFECTIONS in northern Wisconsin, Coxsackie 129
VISION SCREENING PROGRAM, school, An outline to facilitate the development of a ---- 339

WILL AND ESTATE, The physician's ---- 21
WISCONSIN PHYSICIANS SERVICE, Facts about -- 11–35, 12–27
See also Blue Shield of Wisconsin
Wisconsin Press–Commentator, The ---- 5–26, 360, 424, 476, 9–26, 584, 622, 12–22
See also Comments from the Wisconsin press

X-RAYING, Chest, of general hospital admissions -- 562

1953 Medical Forum Index

Page

AMERICAN ACADEMY OF GENERAL PRACTICE, calls Hawley's statements disservice to medicine 294
— Hildebrand to head 295

AMERICAN LEGION, sponsors nurse's training 461

AMERICAN MEDICAL ASSOCIATION, contributes $5,000 for Netherlands relief 196
— Dr. Turner takes over as council head 609
— former Wisconsinite is head of new body 532
— If you can't be at clinical session, see it on TV 604
— inauguration of Dr. McCormick will be on national hookup 293
— outlines its position on proposed legislation 344
— publishes a new booklet for public 148
— scores again with radio broadcast series 246
— seeks reduction for doctors taking postgraduate courses 406
— state MD's attend meeting in New York 348
— voices support of two U. S. Senate bills 293
— Wisconsin special to San Francisco 570

AMERICAN MEDICAL EDUCATION FOUNDATION, Bauer made president of 708
— business, industrial leaders discuss help for 708
— Gundersen re-elected to 196
— needs Wisconsin contributions 703
— will accept gifts to memorial fund 62

ASSOCIATION FOR THE EDUCATION OF THE MENTALLY HANDICAPPED CHILD, honored for voluntary service 60

ATTIC ANGELS, create heaven for invalids 528

BEAUMONT MEMORIAL, cornerstone laid on Mackinac Island 461

BEAUTY AND HEALTH, magazine for druggists gets AMA cooperation 343

BI-PARTISAN COMMISSION, will make federal-state study 241

BLOOD CENTERS, to continue operation; defense centers closed 464

BLUE CROSS, hospitals need closer tie-up, Msgr. McGowan says 196
— pays $50,000,000 to hospitals 406
— re-elects B. E. Miller president 293
— reports record year at annual meeting 294
— seven new physicians added to corporate membership 348

BLUE SHIELD, association releases 1952 figures 610
— donates for long illness study 464

BOARD OF PHARMACY, court renders decision for 294

BRICKER RESOLUTION
— Dane County hears debate on 703

BUIE, DR. LOUIS A., asks help in revising principles of medical ethics 142

BYRNES, REP. JOHN W., tells Outagamie MD's to watch VA policies, socialization 710

CHIROPRACTIC, 5 bills defeated; lose bid to be called "Doctor" 401
— Langer will give a boost to 708
— New York continues to refuse licenses 298
— "Science vs. Chiropractic" is recommended reading 192

CIO, wants to help shape policies of prepaid insurance 345

CIVIL DEFENSE, eleven teams prepared; stockpiling goes on 527
— medical aspects of, discussed at governor's conference 603
— "operation A-Bomb" new film for public 197
— plasma for emergency use contracted for by 295
— state level plans for, move forward 459
— Southworth completes manual for medical teams of 291

CLINICAL CENTER, first patients admitted to new 465

COMMISSION ON STATE DEPARTMENTS, meets in Madison, appoints new members 291
— members named to 145
— model school vision screening plan outlined 296
— state officials outline plans to 144

COMMUNITY ENROLLMENT, tried in Manitowoc county 525

COMPULSORY HEALTH INSURANCE, in Sweden 463
— part of Truman report called 55
— push petition on Canadian health plan 59

COON, DR. H. M., placed on hospital council 610
— valley TB conference elects officer 708

Page

COST OF MEDICAL CARE, coal miners' costs 50 millions 58
— Eau Claire area to be surveyed 297

COUNCIL, adopts increases under Provident plan 342
— approves construction of new SMS building 459
— makes important decisions at May meeting 341
— picks group for liaison with pharmacists 462

COUNCIL COMMITTEES, members named for 1953–54 297

COUNTY MEDICAL SOCIETIES, all Washington–Ozaukee members contribute to medical education fund 570
— Byrnes tells Outagamie MD's to watch VA policies, socialization 710
— Dane County hears debate on Bricker Resolution 703
— Dodge County Society confers with newsmen 241
— emergency call service starts in Fond du Lac 405
— immunization clinics resumed in Appleton 710
— 22 Marinette MD's contribute to SMS Student Loan Fund 146
— members in 71 towns give volunteer bloodmobile service 143

CRAFTS, MISS GRACE, hospital award of merit goes to 198

CROWNHART, C. H., elected to fellowship in Public Health Association 408

DAVIS, CONGRESSMAN GLENN, gives figures on federal employees 146

DEICHER, DR. HENRY, Plymouth club honors 346

DESSLOCH, DR. E. M., talks about future catastrophic policy 603

DEVITT, DR. J. S., heads nursing survey 408

DRAHEIM, MRS. WILLIAM A., claims socialized medicine "not for us" 568
— "let's not have government tinker with medicine" 606

DUFOUR, ROBERT, named executive secretary of general practice 198

EISENHOWER, DWIGHT D., backs fund campaign 569
— campaign special carried a masseur, not a chiro 342
— signs new "doctor draft" law 404
— Taft are agreed on commission 60

EPILEPTICS, marriage of, legalized in state 405

EXHIBITS, medical care and where medical dollar goes are subjects 346

FEDERAL BUDGETS, for health and medical programs in excess of $1,775,882,197 707

FEDERAL EMPLOYEES, health set-up to be evaluated 61
— streamlining of health set-ups proposed 196

FEDERAL SECURITY AGENCY, gets departmental status 239

FOOD AND DRUG ADMINISTRATION, bans cancer diagnosis kits 243
— no chance for snake oil spielers here 710
— points out two serious gaps in our existing laws 148
— quack cure-alls seized by 461

FORD, BENSON, tells doctors not to be so conservative 406

FOWZER, DR. LLOYD, is up to old tricks again 246

FTC, questions value of "Rutin" 60

GOEBEL, MSGR. E. J., Catholic hospital group picks 606

GOVERNMENT, U. S., writes 5 billions in insurance 403

GUNDERSEN, DR. GUNNAR, head of commission 59
— re-elected to Education Foundation 196

4–H CLUBS, twenty-seven get SMS awards for good health programs 147

HEALTH CONFERENCE, citations presented to Mrs. McClelland, Kenosha Health Council 605
— Dessloch talks about future catastrophic policy 603
— Mrs. Wahlquist to be heard on WHA 610
— set for November 4 and 5 in Madison 567
— stresses need for health departments 607

HIGH SCHOOL ESSAY CONTEST, scheduled 571

HIGLEY, HARVEY, Eisenhower announces to be VA chief 466

Page

HILDEBRAND, DR. W. B., to head Academy of General Practice next year 295

HILL–BURTON ACT, would be extended to 1960 by Hill, Taft 196

HIRSCH, DR. RAYMOND, reappointed to nursing homes group 605

HOBBY, MRS. OVETA CULP, chooses Mrs. Spaulding as assistant 292
— Dartmouth prof. becomes assistant 460
— special assistant Boston MD 532
— to have MD as special assistant 239

HORMAN, S. L., made chairman of chamber committee 143

HOSPITAL CONSTRUCTION, act would be extended to 1960 by Hill, Taft 196
— approved for Wisconsin 59
— community effort, built new Hudson Memorial Hospital 246
— 21 new hospitals now supply 929 added beds 244
— new Wisconsin hospitals cost over $29,000,000 407
— Wisconsin gains 990 hospital beds with more to come 529

HOSPITAL COUNCIL, solved agency payment problem 242

JUSTICE DEPARTMENT, cuts its spending 62

KASTEN, DR. H. E., is elected head of conference 610

KOHLER, GOVERNOR WALTER, names 5 new members to Board of Medical Examiners 405
— signs revised medical practice act 401
— to study school's problems 407

LACROSSE STATE COLLEGE, offers degree in medical technology 567

LAIRD, REP. MELVIN, VA budget letters swamp 402

LANGER, SEN. WILLIAM, will give a boost to chiropractic 708

LEGISLATION, abolish statutes certifying midwives 402
— both parties work for betterment of health 461
— 5 chiropractic bills defeated; lose bid to be called "Doctor" 401
— foreign students may get temporary educational certificates 403
— governor signs revised 401
— legislature okays $1,500 for grievance committee 401
— marriage of epileptics legalized 405
— much affecting MD's can be expected 142
— new law okays lay health officers 408
— okay licenses for physical therapists 407
— Robinson and Rasmusen steer health 460
— state statute on auto accident reporting is improved 525

LIABILITY AWARD, court holds municipal hospitals liable for negligence 529
— craziest yet 465
— teachers may face damage suits in injury cases 465

LIFE INSURANCE, companies urged to branch into other fields of insurance 241
— owned by 79 per cent of midwest families 58

LIFE MAGAZINE, "watch it, Life," says AMA journal 460

LULL, DR. GEORGE F., sees future medicine divorced from politics 59

MCCAREY, DR. A. J., is president-elect for 1954 565

MCCORMICK, DR. E. J., calls VA hospital system a chain of medical super-markets 531
— inauguration of, will be on national hookup 293

MEDICAL ECONOMICS, charity patients claim 7 hours of MD's week 342
— doctors' incomes are increased little in relation to others 56
— less than 1 per cent of U. S. population lives 25 miles from any M.D. 530
— skilled labor, physicians get comparable pay 245
— survey shows 80 per cent have no medical debts 347
— two fifths of income of average physician paid out for expenses 406

MEDICAL EDUCATION, fewer students applying for admission to medical schools 466
— launch drive for 62
— MD's gave $3,150,000 in support of 191
— number of graduates, student enrollments reach all-time high 572
— research drains funds from, claims Cornell Dean 195
— states with most MD's have most applicants for 705

Page

MEDICAL SCHOOL, addition vetoed 407
— Wisconsin, Marquette get bequests from trust 192

MICHIGAN, has mobile hearing test chamber 143

MIDDLETON, DR. W. S., on advisory council 298

MIDWIVES, abolish statutes certifying 402

NATIONAL HEALTH COUNCIL, refuses to postpone N. Y. forum 196

NATIONAL HEALTH SERVICES
— British MP tells about 705
— Health Ministry asks druggists to gamble 195

NATUROPATH, bills are defeated 402

NELSON, SENATOR GAYLORD, is able advocate of welfare, health measures 461

NEUPERT, DR. CARL N., heads national health officers' group 141
— is delegate to meeting of World Health Organization 291

NURSE RECRUITMENT, gets boost from auxiliary group 194
— high schools volunteer comments on notebooks 195
— SMS office will be headquarters for activities 341

NURSING EDUCATION, ways to improve, basis of discussions 347

NURSING SCHOOLS, enrollment shows increase 244

OTIS, VINCENT F., becomes president of national hospital group 610

PHARMACY, bill legalizes oral prescription 405
— court sustains "no cause" plea 141
— group tells its platform for 1954 609

PHYSICAL THERAPISTS, okay licenses for 407

PREPAID PLANS, are hard on medical schools 58
— benefits, services get 78.8 per cent of premium dollar 57
— Dessloch talks about future catastrophic policy 603
— expansion of, is nation-wide 58
— hearings on, halted by committee 606
— over 2,000,000 carry in state 57
— Wisconsin contributes to national gain in 569

PRESIDENT'S COMMISSION, becomes private one to promote use of findings 148

PRIVILEGED COMMUNICATIONS, court says psychiatric confidences privileged 60

PROVIDENT PLAN, council adopts increases under 342

PUBLIC RELATIONS, capitol meeting wins Newsweek praise 466
— careers associated with medicine subject of brochure 343
— county highlights call system's importance 343
— edit patient's magizine for MD's waiting rooms 60
— first aid for program chairmen 709
— horse-and-buggy doctor patients' concept of ideal 710
— latest in drive-ins is drive-in hospital 571
— MD's get out leaflets to accompany plaques 403
— MD's urged to continue promoting "Your Doctor" 192
— Medical Associates Brochure distributed 293
— medical, begin with the physician 706
— need a good booklet? 571
— need for mutual understanding stressed 345
— physicians alerted to watch for statements derogatory to medicine 244
— physicians forum success for Florida medical group 239
— pigskin and PR prove a potent combination 571
— police station relays MD's emergency calls 246
— radio, tv seek ban on unethical medical products advertising 709
— tip for February 142
— tip for September 531
— tips for August 462
— "Today's Health" placed in beauty, barber shops 532
— urge your patients to hear broadcasts! 348
— what you can do to assist promotion of "Your Doctor" 192

QUACKS, woman is fined for sale of pills 464

RASMUSEN, ASSEMBLYMAN HOLGER B., and Robinson steer health legislation 460

RED CROSS, will foot gamma globulin bill 198

RESEARCH COUNCIL, releases figures on long illnesses 147

Page

RESEARCH GRANT, University of Wisconsin gets -- 529
— Wisconsin receives $40,000 for heart research 296

REUTHER, WALTER, for program of Magnuson commission 198

REYNOLDS, DAVID, hospital council solved agency payment problem 242

ROBINSON, SENATOR ROBERT P., and Rasmusen steer health legislation 460

RURAL HEALTH, MacCornack eager to see Wisconsin assume prominent place in 240

RYBUTOL, not effective against old age, claim 148

SARGENT, DR. JAMES C., resigns as member of advisory group 525

SCHEELE, DR. LEONARD A., is principal speaker -- 193

SCOTT, DR. MILDRED, new heart, TB control director on Board of Health 197

SELECTIVE SERVICE, advisory committee to continue serving 346
— answers quoted on when a physician can resign commission 463
— Armed Forces pay scale 244
— bill drawn to extend MD's $100 special pay -- 294
— court to review case of reluctant private 61
— determination of rank 609
— Doctor Draft Law extension proposals revealed 197
— final wording of draft bill to be decided 348
— former reservists must register if not yet 50 -- 298
— 471 MDs, 258 dentists in March draft quota -- 192
— national advisory group thinks no more MD's to be called 532
— new doctor draft regulations base rank only on experience 609
— new plan to be used in calling doctors without service 404
— president signs new "doctor draft" law 404
— priority III physicians up to age 38 will be called 244
— Washington advises no young MDs to be deferred for residency 60
— will discontinue induction of priority III's over 31 292

SINCOCK, DR. H. A., and Coon, placed on hospital council 610
— appointed to hospital committee 608
— reappointed to advisory board 531

SOCIAL SECURITY, certify hospitals under new law 407
— propose broad study of 192
— proposed extension of, would cover MD's, dentists 532
— study probably precludes expansion 298

SOCIALIZED MEDICINE, according to Bert Bell, is real political football 605
— is talked down by MD's 293
— "let's not have government tinker with medicine" 606
— representatives in Europe to observe 710
— traveler claims "not for us" 568

SOUTHWORTH, DR. WARREN H., completes manual for medical teams 291

STATE BOARD OF HEALTH, well construction code revisions are initiated 244

STATE BOARD OF MEDICAL EXAMINERS, Kohler names 5 new members to 405
— photographed at its first quarterly meeting -- 464

STATE CHAMBERS OF COMMERCE, suggest return to states of programs 295

STATE LABORATORY OF HYGIENE, dedicated 193

STATE MEDICAL SOCIETY, committees of, discharge public health duties 566
— conducts scientific activities for members 526
— 25 physicians named to committee posts 572
— provides all sorts of advice to members 604
— three labor to keep membership records current 704

STATUTE OF LIMITATIONS, court rules, does not apply to professions 570

STOVALL, DR. W. D., chosen as chairman of section on medical history 341
— sees bright future for public health 191

Page

STUDENT AMA, Marquette has largest convention delegation 245
— Marquette students have strong interest in -- 530

TAFT, SENATOR ROBERT, and Eisenhower are agreed on commission 60
— Hill-Burton Act would be extended by 196
— will head important group 62

TELEVISION, if you can't be at AMA clinical session, see it on 604
— Milwaukee society is cooperating in 146

TENNEY, DR. H. KENT, becomes society's president 565
— physicians must teach young MD's art of healing 565

TOWN, GEORGE G., reappointed as basic science member 343

TURNER, DR. E. L., takes over duties as council head 609

TWO HARBORS COOPERATIVE, sues Duluth medical society 408

UNITED HOSPITALS FUND, staff members give to -- 148

UNITED MINE WORKERS, to build hospitals for miners in 10 towns 462

U. S. TREATY POWERS, may threaten citizenship requirements for MD's 571

VETERANS ADMINISTRATION, AMA head calls hospital system a chain of medical supermarkets -- 531
— applicants for treatment of non-service connected ills must answer questions 608
— bill would abolish inability-to-pay oath 466
— budget letters swamp Rep. Laird 402
— can't override insurance policy "exclusion" clauses 462
— cash benefits to veterans, dependents 141
— conferee's disagreement delays appropriation - 531
— Eisenhower announces Marinette industrialist Higley to be VA chief 466
— Gray announces overhauling of 61
— limits use of ACTH-cortisone for veterans --- 408
— new course of exercise therapy rehabilitates patients 570
— new details of survey become known 146
— racial segregation is ending in hospitals 570
— requires prior approval for use of ACTH, cortisone 567
— screening physicians' reports to curtail unnecessary treatment 709

WAHLQUIST, MRS. HAROLD, to be heard on WHA Saturday, Dec. 5 610

"WAR WITHOUT GUNS", get your copy now! 347

WIPRUD, THEODORE, medical public relations begin with the physician 706

WISCONSIN ACADEMY OF GENERAL PRACTICE, offers two $100 essay awards 197
— Robert Dufour named executive secretary of 198

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION, MD's speak at institutes 705
— offers fellowship for graduate training 464

WISCONSIN HOSPITAL ASSOCIATION, award of merit goes to Miss Grace Crafts 198
— Beloit administrator president-elect of 197

WISCONSIN LAWMAKERS, introduce four bills touching health field 348

WISCONSIN PUBLIC HEALTH COUNCIL, elects officers 603

WISCONSIN STATE BOARD OF NURSING, appoints new advisory committee 61

WOMAN'S AUXILIARY, nurse recruitment gets boost from 194

WORLD HEALTH ORGANIZATION, Brazilian with U.S. training heads 466

ZABLOCKI, REP. C. A., would make your wig deductible 194

the Wisconsin Medical Journal

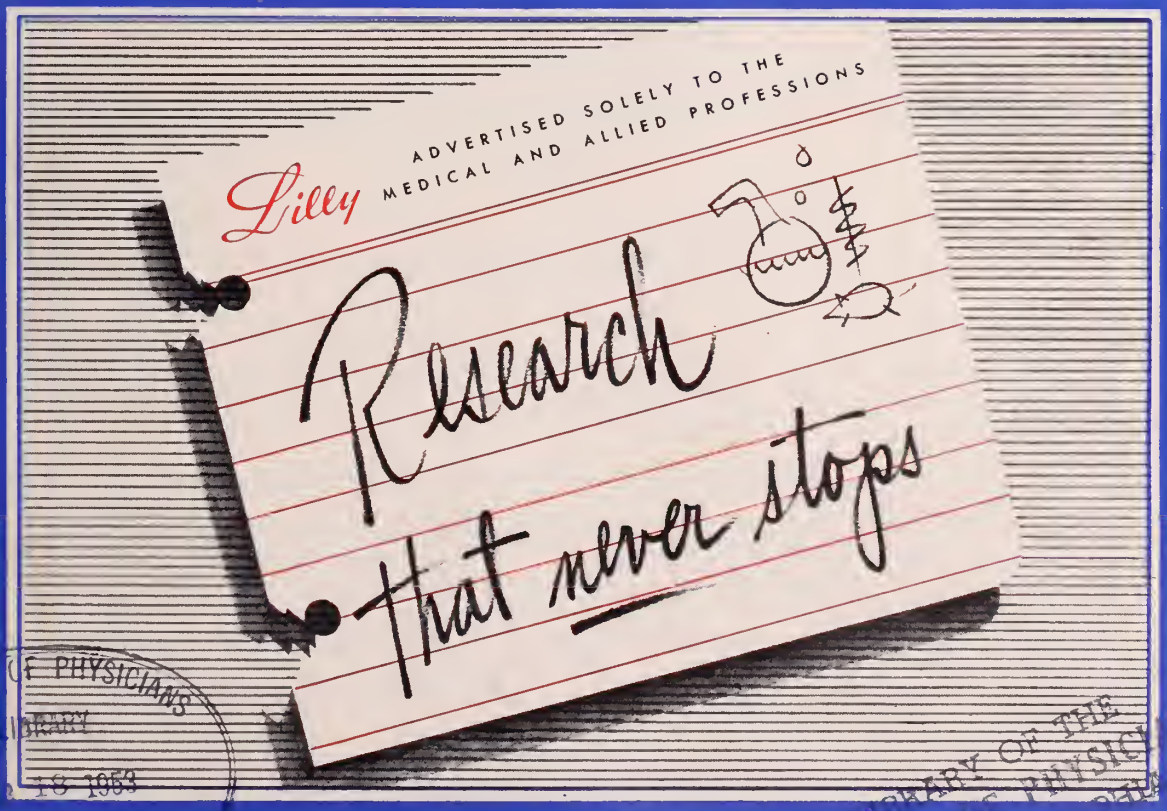
STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

Official Publication of

THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 52–No. 1 January 1953

Supplement to the Wisconsin Medical Blue Book



OF PHYSICIANS
LIBRARY
FEB 18 1953
LIBRARY OF THE
COLLEGE OF PHYSICIANS

in the hands of the physician

Often the critical evaluation of the drug to be administered is as important to the patient's recovery as is the diagnosis of his condition. In each case correct procedures can be determined only by the physician.

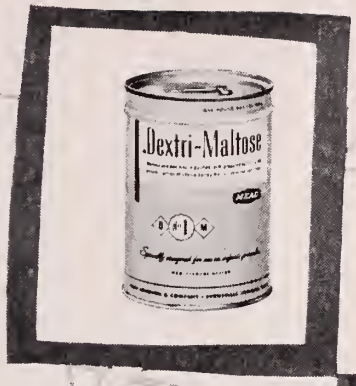
CHLOROMYCETIN is eminent among drugs at the disposal of the medical profession. Clinical findings attest that, in the hands of the physician, this widely used, broad spectrum antibiotic has proved invaluable against a great variety of infectious disorders.

Chloromycetin®

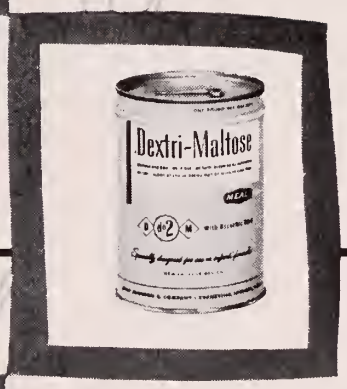
notably effective, well tolerated, broad spectrum antibiotic

The many hundreds of clinical reports on CHLOROMYCETIN emphasize repeatedly its exceptional tolerance as demonstrated by the infrequent occurrence of even mild signs and symptoms of gastrointestinal distress and other side effects in patients receiving the drug.

Similarly, the broad clinical effectiveness of CHLOROMYCETIN has been established, and serious blood disorders following its use are rare. However, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections—and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.



For routine infant feeding. The basic Dextri-Maltose product.



Especially indicated for premature infants. Contains 50 mg. ascorbic acid per ounce.

Dextri-Maltose

MEAD

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U.S.A.

To aid in counteracting constipation. Contains 3% potassium bicarbonate.

designed with singleness of purpose

Designed and manufactured specifically for infant formulas, Dextri-Maltose® has an unequaled background of successful clinical use. Safety for your infant patients is assured by the dry form of this carbohydrate, meticulous laboratory control at all stages in its manufacture, and hermetically sealed, key-opening cans. Dextri-Maltose is palatable but not sweet; does not create a "sweet tooth" in infants. Easily measured without spilling or waste and almost instantly soluble, Dextri-Maltose is convenient for the mother.

Prescribe Journal-advertised products and you prescribe the best.

Owen C. Clark, M. D.
Medical Director
Charles H. Feasler, M. D.
George H. Lohrman, M. D.

Milwaukee Office
By Appointment
Tuesday Morning
Telephone DA 8-1441

The Sanitarium is situated on the Nashotah Lakes, 30 miles west of Milwaukee, providing the ideal, restful country environment and the facilities for the modern methods of therapy of the psychoneuroses, psychosomatic disorders, and the other neurologic and psychiatric problems. Occupational therapy and recreational activities directed by trained personnel.

MILWAUKEE SANITARIUM

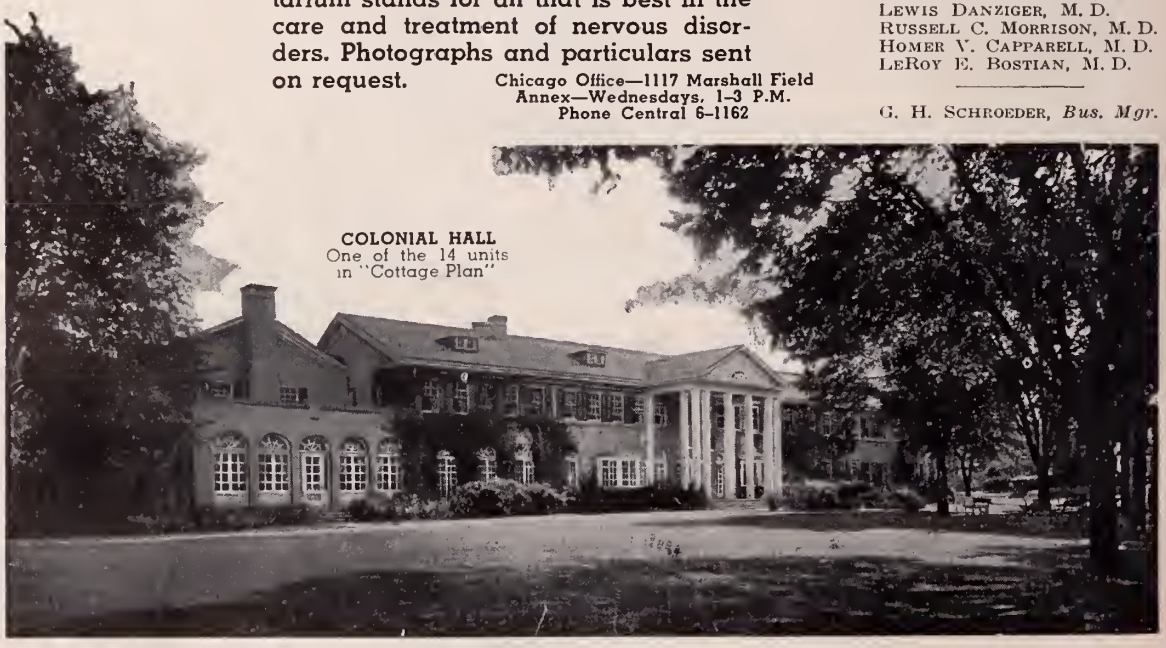
WAUWATOSA
WISCONSIN

Maintaining the highest standards for more than a half century this Sanitarium stands for all that is best in the care and treatment of nervous disorders. Photographs and particulars sent on request.

Chicago Office—1117 Marshall Field Annex—Wednesdays, 1-3 P.M.
Phone Central 6-1162

JOSEF A. KINDWALL, M. D.
CARROLL W. OSGOOD, M. D.
WILLIAM T. KRADWELL, M. D.
BENJAMIN A. RUSKIN, M. D.
LEWIS DANZIGER, M. D.
RUSSELL C. MORRISON, M. D.
HOMER V. CAPPARELL, M. D.
LEROY E. BOSTIAN, M. D.

G. H. SCHROEDER, *Bus. Mgr.*



DEMOCRAT PRINTING COMPANY
MADISON, WISCONSIN

TEL

the Wisconsin Medical Journal

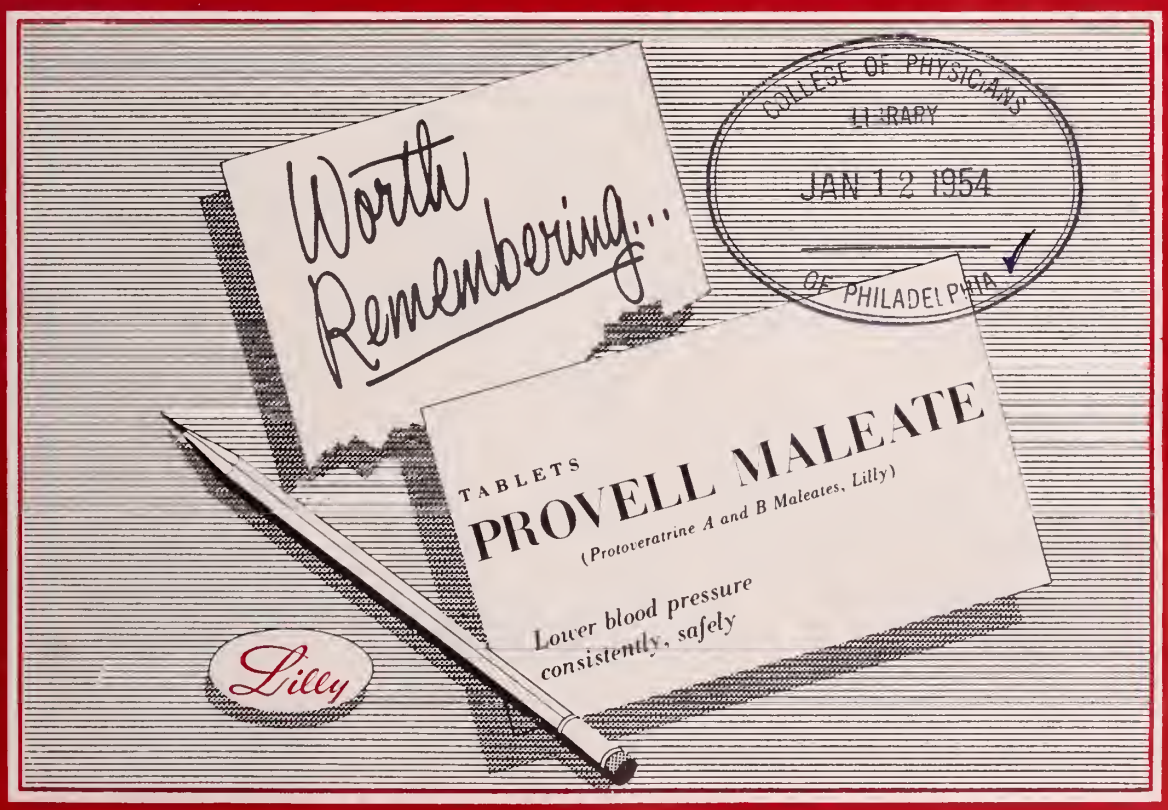
STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

Official Publication of

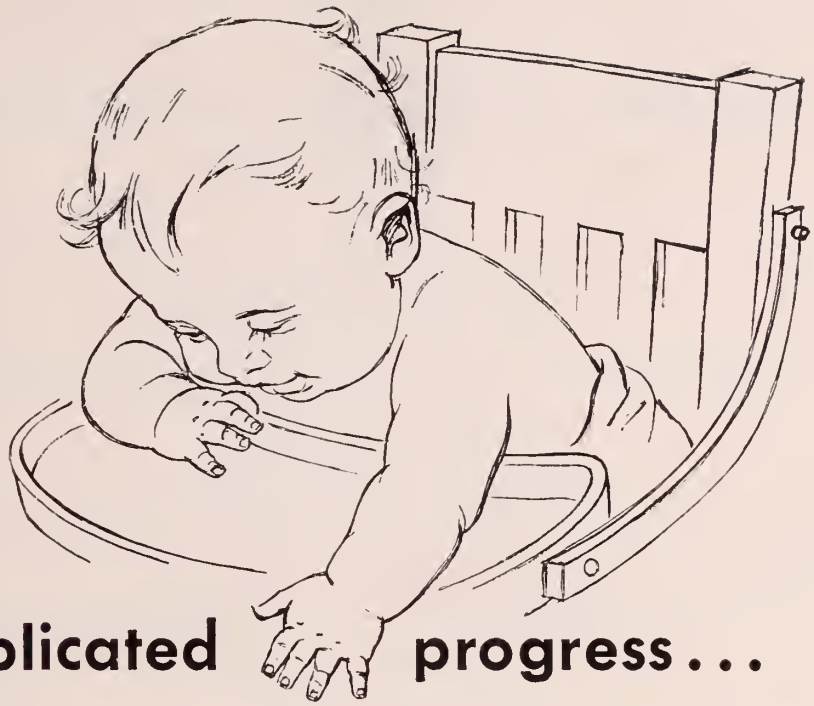
THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 52—No. 12 December 1953

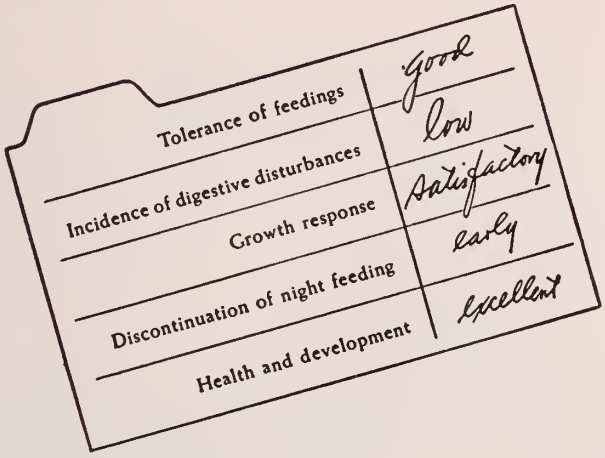
COLLEGE OF PHYSICIANS
LIBRARY
JAN 12 1954
OF PHILADELPHIA



moderates the menopaus



uncomplicated progress . . .



The uncomplicated nutritional progress[1] of infants fed Lactum® speaks for its sound rationale. Lactum is Mead's liquid formula made from whole milk and Dextri-Maltose.®

It provides generous milk protein for sturdy growth and sound tissue structure, with sufficient calories to spare protein and meet the infant's energy needs.

Lactum is convenient and easy to prepare—simply mix equal parts of Lactum and water for a formula supplying 20 calories per fluid ounce.

1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.

Lactum

MEAD

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U. S. A.

ROGERS MEMORIAL SANITARIUM

OCONOMOWOC, WISCONSIN

Announces the Opening of an

OUT-PATIENT DEPARTMENT

For the diagnosis and treatment of Psychiatric disorders

Under the direction of

ANNETTE C. WASHBURNE, M. D.

Diplomate of American Board of Psychiatry and Neurology

Formerly Professor of Psychiatry

University of Wisconsin

Consultation by appointment **Phone Oconomowoc 448**

MILWAUKEE SANITARIUM

WAUWATOSA
WISCONSIN

Maintaining the highest standards since 1884, the Milwaukee Sanitarium continues to stand for all that is best in the care and treatment of nervous disorders. Photographs and particulars sent on request.

Chicago Office—1509 Marshall Field Annex Bldg.—25 E. Washington St.—Wednesday, 1–3 P.M. Phone: Central 6–1162

JOSEF A. KINDWALL, M. D.
CARROLL W. OSGOOD, M. D.
WILLIAM T. KRADWELL, M. D.
BENJAMIN A. RUSKIN, M. D.
LEWIS DANZIGER, M. D.
RUSSELL C. MORRISON, M. D.
JAMES A. ALSTON, M. D.

WALDO W. BUSS, *Exec. Dir.*

COLONIAL HALL
One of the 14 units in "Cottage Plan"

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. **No further preliminary notice will be sent.** Requests for renewals must be made on or before the date of expiration.

DUE	RETURNED
DEC 6 1954	NOV 29 1954
NOV 15 1955	NOV 3 1955
JUL 6 1956	
SEP 4 1957	
FEB 20 1961	
NOV 15 1963	

A fine of twenty-five cents will be charged for each week or fraction of a week the book is retained without the Library's authorization.